60 p.

MONTANA LEGISLATIVE HISTORY

Chapter 342 ~~19~~ 2001

Bill H _____ S 466 Original bill & history ✓C

H. Committee on Human Services

Hearing Date(s) _____ C

_____ C

3/26 ✓C

_____ C

Date Out 3/27 ✓C

S. Committee on Public Health

Hearing Date(s) _____ ✓C

2/16 ✓C

_____ C

3/14 ✓C

* House amendments included

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

2/20	Committee Executive Action--Bill Passed as Amended	9	0
2/20	Committee Report--Bill Passed as Amended		
2/22	2nd Reading Passed on Voice Vote	50	0
2/22	3rd Reading Passed	50	0
	Transmitted to House		
3/03	Referred to Business and Labor		
3/22	Hearing		
3/27	Committee Executive Action--Bill Concurred as Amended	18	1
3/27	Committee Report--Bill Concurred as Amended		
3/29	2nd Reading Concurred	97	1
3/31	3rd Reading Concurred	97	3
	Returned to Senate with Amendments		
4/04	2nd Reading House Amendments Concurred on Voice Vote	49	0
4/05	3rd Reading Passed as Amended by House	49	0
4/05	Sent to Enrolling		
4/07	Returned from Enrolling		
4/10	Signed by President		
4/10	Signed by Speaker		
4/11	Transmitted to Governor		
4/21	Signed by Governor		
4/21	Chapter Number Assigned		

Chapter Number 341
Effective Date: 4/21/2001 - Sections 4, 7(22), 11(1), and 12 -14
Effective Date: 7/01/2001 - Sections 1-3, 5, 6, 7(1)-7(21), 8-10, 11(2), and 15

166 Introduced by Waterman *LC0366 Drafter: Fox*

Revise Mental Health Commitment Laws

2/13	Introduced		
2/13	First Reading		
2/13	Referred to Public Health, Welfare and Safety		
2/16	Hearing		
2/16	Fiscal Note Requested		
2/16	Fiscal Note Received		
2/17	Fiscal Note Signed		
2/17	Fiscal Note Printed		
3/16	Committee Executive Action--Bill Passed as Amended	8	2
3/16	Committee Report--Bill Passed as Amended		
3/19	2nd Reading Passed on Voice Vote	47	1
3/20	3rd Reading Passed	47	2
	Transmitted to House		
3/21	Referred to Human Services		
3/26	Hearing		
3/27	Committee Executive Action--Bill Concurred as Amended	17	1
3/27	Committee Report--Bill Concurred as Amended		
3/30	2nd Reading Concurred as Amended	99	1
3/31	3rd Reading Concurred	95	5
	Returned to Senate with Amendments		
4/05	2nd Reading House Amendments Concurred on Voice Vote	47	1
4/06	3rd Reading Passed as Amended by House	46	1
4/06	Sent to Enrolling		
4/09	Returned from Enrolling		
4/10	Signed by President		
4/10	Signed by Speaker		
4/12	Transmitted to Governor		
4/21	Signed by Governor		

Senate BILL NO. 466

INTRODUCED BY Mayor Waterman
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE MENTAL HEALTH COMMITMENT STATUTES; ALLOWING THE COURT TO ORDER ASSISTED OUTPATIENT TREATMENT FOR A PERIOD NOT TO EXCEED 12 MONTHS; PROVIDING FOR FINDINGS, TREATMENT PLANS, PROVIDER CHOICE, AND CONDITIONS TO OBTAIN AN ORDER FOR ASSISTED OUTPATIENT TREATMENT; PROVIDING FOR APPEARANCE OF TREATING PROVIDERS AND RESPONDENTS BEFORE THE COURT EVERY 3 MONTHS; PROVIDING FOR WRITTEN REPORTS BY THE TREATING PROVIDER TO THE COURT; PROVIDING THAT A REFERRAL FOR APPROPRIATE MENTAL ILLNESS PROCEEDINGS IS AN APPROPRIATE CONDITION OF PRETRIAL DIVERSION; AND AMENDING SECTIONS 46-16-130, 53-21-104, 53-21-121, 53-21-123, 53-21-124, 53-21-126, 53-21-127, 53-21-128, AND 53-21-181, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Conditions of assisted outpatient treatment in a community facility, program, or course of treatment.** If the court orders a disposition under 53-21-127(3)(b), the court may order the following conditions for assisted outpatient treatment in a community facility or program, or may order a course of treatment, including but not limited to:

(1) following a treatment plan that may include case management services, medication, short-term inpatient treatment, or chemical dependency treatment, as set forth by the designated community facility or program or the individual responsible for the management and supervision of the respondent's treatment; or

(2) specific residential or housing requirements that may include being under the care or custody of a relative or guardian.

NEW SECTION. **Section 2. Assisted outpatient treatment -- findings -- inability to make rational treatment decision -- rebuttable presumption.** (1) The court ordering a respondent to receive assisted outpatient treatment shall make the following findings of fact:

(a) that for at least one recent extended period, the respondent has failed substantially to follow

a reasonable treatment plan without reasons or without adequate justification, which resulted in at least one of the conditions in 53-21-126(1);

(b) subject to the determination required in 53-21-190, that the respondent has previously been determined to be suffering from a mental disorder and has received treatment in an inpatient hospital pursuant to this part; and

(c) as a result of the respondent's mental disorder, that the respondent lacks the capacity to make rational treatment decisions.

(2) For the purposes of this section, "rational treatment decision" means a decision based on plausible or good reasons. A respondent's treatment decision that is medically inadvisable or that conflicts with the recommendations of a professional person treating the respondent may be rational if the decision is based on plausible or good reasons. A respondent's refusal to follow a professional person's reasonable treatment plan remains a rational treatment decision if the refusal reflects a good faith attempt to follow a reasonable alternative treatment plan or if it is protected by a constitutional right to refuse treatment.

(3) If the respondent has substantially complied for the prior 12 months with any current treatment plans or recommendations made as a result of proceedings previously initiated under this chapter or with the current treatment recommendations of any other professional person treating the respondent, a rebuttable presumption arises that the respondent has the capacity to make rational treatment decisions. In deciding whether that presumption is overcome, the court shall consider, among other factors, how frequently and how recently the respondent has failed to follow reasonable treatment recommendations and whether any failures, if they exist, have led to the respondent's inability to provide for the respondent's basic needs for food, shelter, clothing, health, or safety or have led to self-endangerment or to the respondent being dangerous to others.

NEW SECTION. **Section 3. Assisted outpatient treatment plan -- provider choice [-- advanced directive].** (1) Stabilizing treatment must be provided during the development of a treatment plan.

(2) The chief medical officer of the facility or program at which the respondent has been ordered to receive outpatient treatment and at which the respondent is treated as an outpatient or the chief medical officer's designee shall submit a treatment plan, including any outpatient treatment recommendations that the respondent is required to follow, to the clerk of district court as soon as practical. However, the plan must be submitted no later than 30 days after the respondent has been

ordered to receive treatment as an outpatient.

(3) A treatment plan must be developed with the respondent and the friend of respondent or respondent's family and must respect any durable powers of attorney [or advanced directives] in effect at the time of the order.

(4) The clerk of district court shall send a copy of the proposed treatment plan to the court, to the respondent, to the friend of respondent, and to the respondent's attorney of record, who may relay the respondent's objections to the treatment plan, if any, and provide alternative treatment recommendations to the court.

(5) The court may accept the treatment plan or require a revised treatment plan that is approved by a mental health professional.

(6) If the respondent wishes to receive outpatient treatment from a different mental health professional or a facility or program that is willing to treat the respondent as a court-ordered outpatient under the approved treatment plan, the court shall order the respondent to the care of that professional person, facility, or program upon the respondent's written request.

(7) A respondent may execute a durable power of attorney for health care decisions, in accordance with 72-5-501[, or an advanced directive]. If legally sufficient pursuant to Title 72, chapter 31, part 2, a durable power of attorney for health care decisions [or an advance directive pursuant to LC 1415] is binding on the court and on any professional person provided that the decisions made by the agent possessing the power of attorney and the instructions, if any, in the executed power of attorney for health care decisions [or in the advance directive] are within accepted medical standards and practices. This section does not require a mental health professional to accept as an outpatient a respondent who has executed a durable power of attorney for health care decisions [or an advance directive] that provides for treatment, whether by instructions or by decisions of the person possessing the power of attorney, that in the mental health professional's judgment would not be an appropriate treatment for the respondent's condition.

NEW SECTION. **Section 4. Periodic reports -- failure to file.** (1) The chief medical officer of the facility or program where the respondent obtains treatment as an outpatient or the chief medical officer's designee shall appear with the respondent before the court and furnish written reports on the respondent's progress every 3 months. At the court appearance, the respondent and the treating provider may seek

amendment of the treatment plan or dismissal of the treatment order as provided in 53-21-181 and 53-21-182.

(2) The chief medical officer shall provide a copy of the report to the respondent, to the respondent's counsel, and to the friend of respondent.

(3) If a progress report required in subsection (1) is not filed in a timely manner or if services to a respondent are not provided, the court shall inform the department. The department or a designee shall make a determination regarding whether the respondent's treatment is being publicly funded, and if it is publicly funded, the department shall refer the services to utilization review to determine if there is appropriate action to take regarding the treating provider.

NEW SECTION. **Section 5. Notification of noncompliance to assisted outpatient treatment -- response.** (1) If the respondent does not substantially comply with the treatment plan developed pursuant to the order for assisted outpatient treatment, the chief medical officer or designee shall promptly notify the court upon becoming aware of substantial noncompliance and shall provide supporting documentation.

(2) The court may take reasonable steps to ensure compliance with the court's outpatient treatment order, including but not limited to the following:

(a) directing that the friend of respondent remind the respondent of the respondent's treatment obligations and attempt to persuade the noncompliant respondent to comply with the treatment plan;

(b) presenting the respondent to the mental health facility or program for treatment, including administration of medication pursuant to 53-21-127(6); or

(c) directing the treating provider to work with the respondent to bring about compliance with the treatment plan.

(3) The court may order the respondent and the treating provider to appear before the court. If necessary the court may order the sheriff to bring the respondent before the court.

(4) Unless the court has good reason, based upon past experience with the respondent or the friend of respondent, to believe that the methods in subsections (1) through (3) will not be effective in ensuring compliance with the court's outpatient treatment order or that immediate treatment is necessary, the court shall attempt to secure compliance by one or more of the reasonable steps provided for in subsections (1) through (3) before ordering the sheriff to bring the noncompliant respondent to treatment. If necessary, the court shall order the sheriff to bring the respondent to the facility or program for

treatment.

NEW SECTION. **Section 6. Department funding responsibility for assisted outpatient treatment.** The department shall develop a separate funding category and procedure for payment for services that are court-ordered for assisted outpatient treatment if the individual under the commitment is eligible for mental health services under the public mental health system.

Section 7. Section 46-16-130, MCA, is amended to read:

"46-16-130. Pretrial diversion. (1) (a) Prior to the filing of a charge, the prosecutor and a defendant who has counsel or who has voluntarily waived counsel may agree to the deferral of a prosecution for a specified period of time based on one or more of the following conditions:

(i) that the defendant may not commit any offense;

(ii) that the defendant may not engage in specified activities, conduct, and associations bearing a relationship to the conduct upon which the charge against the defendant is based;

(iii) that the defendant shall participate in a supervised rehabilitation program, which may include treatment, counseling, training, or education;

(iv) that the defendant shall make restitution in a specified manner for harm or loss caused by the offense; or

(v) any other reasonable conditions.

(b) The agreement must be in writing, must be signed by the parties, and must state that the defendant waives the right to speedy trial for the period of deferral. The agreement may include stipulations concerning the admissibility of evidence, specified testimony, or dispositions if the deferral of the prosecution is terminated and there is a trial on the charge.

(c) The prosecution must be deferred for the period specified in the agreement unless there has been a violation of its terms.

(d) The agreement must be terminated and the prosecution automatically dismissed with prejudice upon expiration and compliance with the terms of the agreement.

(2) A condition of pretrial diversion may be for the court to refer a defendant for evaluation to determine the appropriateness of proceedings pursuant to Title 53, chapter 21.

~~(2)~~(3) After a charge has been filed, a deferral of prosecution may be entered into only with the

approval of the court.

~~(3)~~(4) A prosecution for a violation of 61-8-401, 61-8-406, or 61-8-410 may not be deferred."

Section 8. Section 53-21-104, MCA, is amended to read:

"**53-21-104. Powers and duties of mental disabilities board of visitors.** (1) The board is an independent board of inquiry and review to assure that the treatment of all persons either voluntarily or involuntarily admitted to a mental facility is humane and decent and meets the requirements set forth in this part.

(2) The board shall review all plans for experimental research involving persons admitted to a mental health facility to assure that the research project is humane and not unduly hazardous and that it complies with the principles of the statement on the use of human subjects for research of the American association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare. An experimental research project involving persons admitted to a mental health facility affected by this part may not be commenced unless it is approved by the mental disabilities board of visitors.

(3) The board shall at least annually inspect every mental health facility ~~which~~ that is providing treatment and evaluation to any person pursuant to this part. The board shall inspect the physical plant, including residential, recreational, dining, and sanitary facilities. ~~It~~ the board shall visit all wards and treatment areas. The board shall inquire concerning all treatment programs being implemented by the facility.

(4) The board shall annually insure that a treatment plan exists and is being implemented for each patient admitted or committed to a mental health facility under this part. The board shall inquire concerning all use of restraints, isolation, or other extraordinary measures.

(5) The board may assist any patient at a mental health facility in resolving any grievance the patient may have concerning the patient's commitment or course of treatment in the facility.

(6) The board shall employ and be responsible for full-time legal counsel at the state hospital, whose responsibility is to act on behalf of all patients at the institution. The board shall insure that there is sufficient legal staff and facilities to insure availability to all patients and shall require that the appointed counsel periodically interview every patient and examine the patient's files and records. The board may employ additional legal counsel for representation of patients in a similar manner at any other mental health

facility having inpatient capability.

(7) If the board believes that any facility is failing to comply with the provisions of this part in regard to its physical facilities or its treatment of any patient, it shall report its findings at once to the professional person in charge of the facility and the director of the department, and if appropriate, after waiting a reasonable time for a response from the professional person, the board may notify the next of kin or guardian of any patient involved, the friend of respondent appointed by the court for any patient involved, and the district court which has jurisdiction over the facility.

(8) The board shall report annually to the governor concerning:

(a) the status of the mental health facilities and treatment programs which it has inspected; and

(b) medications involuntarily administered to patients in mental health facilities and the effectiveness of the review procedure required by 53-21-127~~(2)~~(6) in protecting patients from unnecessary or excessive medication."

Section 9. Section 53-21-121, MCA, is amended to read:

"**53-21-121. Petition for commitment -- contents of -- notice of.** (1) The county attorney, upon the written request of any person having direct knowledge of the facts, may file a petition with the court alleging that there is a person within the county who is suffering from a mental disorder and who requires commitment pursuant to this chapter.

(2) The petition must contain:

(a) the name and address of the person requesting the petition and the person's interest in the case;

(b) the name of the respondent and, if known, the address, age, sex, marital status, and occupation of the respondent;

(c) the purported facts supporting the allegation of mental disorder, including a report by a mental health professional if any, a statement of the disposition sought pursuant to 53-21-127~~(2)~~, and the need for commitment;

(d) the name and address of every person known or believed to be legally responsible for the care, support, and maintenance of the respondent for whom evaluation is sought;

(e) the name and address of the respondent's next of kin to the extent known to the county attorney and the person requesting the petition;

(f) the name and address of any person whom the county attorney believes might be willing and able to be appointed as friend of respondent;

(g) the name, address, and telephone number of the attorney, if any, who has most recently represented the respondent for whom evaluation is sought; if there is no attorney, there must be a statement as to whether to the best knowledge of the person requesting the petition the respondent for whom evaluation is sought is indigent and unable to afford the services of an attorney; and

(h) a statement of the rights of the respondent, which must be in conspicuous print and identified by a suitable heading.

(3) Notice of the petition must be hand-delivered to the respondent and to the respondent's counsel on or before the initial appearance of the respondent before the judge or justice of the peace. The respondent's counsel shall meet with the respondent, explain the substance of the petition, and explain the probable course of the proceedings. Notice of the petition and the order setting the date and time of the hearing and the names of the respondent's counsel, professional person, and friend of respondent must be hand-delivered or mailed to the person or persons legally responsible for care, support, and maintenance of the respondent, the next of kin identified in the petition, and any other person identified by the county attorney as a possible friend of respondent other than the one named as the friend of respondent. The notice may provide, other than as to the respondent and the respondent's counsel, that no further notice will be given unless written request is filed with the clerk of court."

Section 10. Section 53-21-123, MCA, is amended to read:

"53-21-123. Examination of respondent following initial hearing -- recommendation of professional person. (1) Following the initial hearing, whether before a judge or justice of the peace, the respondent must be examined by the professional person without unreasonable delay. The examination may not exceed a period of 4 hours. The professional person shall immediately notify the county attorney of the findings in person or by phone and shall make a written report of the examination to the court, with copies to the respondent's attorney and the county attorney. If the professional person recommends commitment, the professional person's written report must contain a statement of the professional person's recommendations to the court for disposition under 53-21-127~~(2)~~.

(2) The following action must be taken based on the professional person's findings:

(a) If the professional person recommends dismissal, the professional person shall additionally

notify counsel and the respondent must be released and the petition dismissed. However, the county attorney may, upon good cause shown, request the court to order an additional, but no more than one, examination by a different professional person for a period of no more than 4 hours.

(b) If the court finds that commitment proceedings should continue, the hearing must be held as scheduled.

(3) The court may not order further evaluation pending the hearing unless sound medical reasons require additional time for a complete evaluation. The reasons must be set forth in the order, along with the amount of additional time needed."

Section 11. Section 53-21-124, MCA, is amended to read:

"53-21-124. Detention of respondent pending hearing or trial -- jail prohibited. (1) The court may not order detention of a respondent pending the hearing unless requested by the county attorney and upon the existence of probable cause for detention. Counsel must be orally notified immediately. Counsel for the respondent may then request a detention hearing, which must be held ~~forthwith~~ immediately.

(2) In the event of detention, the respondent must be detained in the least restrictive setting necessary to ~~assure his~~ ensure the respondent's presence and ~~assure his safety and~~ ensure the safety of the respondent and of others as provided in 53-21-120.

(3) If the respondent is detained, ~~he~~ the respondent has the right to be examined additionally by a professional person of ~~his~~ the respondent's choice, which may not depend on the respondent's ability to pay, and the respondent must be informed of this right. Unless objection is made by counsel for the respondent, ~~he~~ the respondent must continue to be evaluated and treated by the professional person pending the hearing.

(4) A respondent may not be detained in a jail or other correctional facility pending a hearing or trial to determine whether the respondent should be committed to a mental health facility."

Section 12. Section 53-21-126, MCA, is amended to read:

"53-21-126. Trial or hearing on petition. (1) The respondent must be present unless the respondent's presence has been waived as provided in 53-21-119(2), and the respondent must be represented by counsel at all stages of the trial. The trial must be limited to the determination of whether or not the respondent is suffering from a mental disorder and requires commitment. At the trial, the court

shall consider all the facts relevant to the issues of whether the respondent is suffering from a mental disorder. If the court determines that the respondent is suffering from a mental disorder, the court shall then determine whether the respondent requires commitment. In determining whether the respondent requires commitment, the court shall consider the following:

(a) whether the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) whether the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) whether, because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; and

(d) whether the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(2) The standard of proof in a hearing held pursuant to this section is proof beyond a reasonable doubt with respect to any physical facts or evidence and clear and convincing evidence as to all other matters. However, the respondent's mental disorder must be proved to a reasonable medical certainty. Imminent threat of self-inflicted injury or injury to others must be proved by overt acts or omissions, sufficiently recent in time as to be material and relevant as to the respondent's present condition.

(3) The professional person appointed by the court must be present for the trial and subject to cross-examination. The trial is governed by the Montana Rules of Civil Procedure. However, if the issues are tried by a jury, at least two-thirds of the jurors shall concur on a finding that the respondent is suffering from a mental disorder and requires commitment. The written report of the professional person that indicates the professional person's diagnosis may be attached to the petition, but any matter otherwise inadmissible, such as hearsay matter, is not admissible merely because it is contained in the report. The court may order the trial closed to the public for the protection of the respondent.

(4) The professional person may testify as to the ultimate issue of whether the respondent is suffering from a mental disorder and requires commitment. This testimony is insufficient unless accompanied by evidence from the professional person or others that:

(a) the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; or

(d) (i) the respondent's mental disorder:

(A) has resulted in recent acts, omissions, or behaviors that create difficulty in protecting the respondent's life or health;

(B) is treatable, with a reasonable prospect of success;

(C) has resulted in the respondent's refusing or being unable to consent to voluntary admission for treatment; and

(ii) will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(5) If the petition seeks an order for assisted outpatient treatment, as provided in 53-21-127, the evidence must include testimony:

(a) that for at least one recent extended period, the respondent has failed to follow any reasonable treatment plan without reasons or without adequate justification, which resulted in at least one of the conditions in 53-21-126(1);

(b) that the individual has previously been determined to be suffering from a mental disorder and received treatment in an inpatient hospital pursuant to this part; and

(c) as a result of the individual's mental disorder, that the respondent lacks the capacity to make rational treatment decisions.

~~(5)~~(6) The court, upon the showing of good cause and when it is in the best interests of the respondent, may order a change of venue."

Section 13. Section 53-21-127, MCA, is amended to read:

"53-21-127. Posttrial disposition. (1) If, upon trial, it is determined that the respondent is not

suffering from a mental disorder or does not require commitment within the meaning of this part, the respondent must be discharged and the petition dismissed.

(2) ~~(a)~~ If it is determined that the respondent is suffering from a mental disorder and requires commitment within the meaning of this part, the court shall hold a posttrial disposition hearing. The disposition hearing must be held within 5 days (including Saturdays, Sundays, and holidays unless the fifth day falls on a Saturday, Sunday, or holiday), during which time the court may order further evaluation and treatment of the respondent.

(3) At the conclusion of the disposition hearing, the court shall:

~~(i)~~(a) commit the respondent to the state hospital for a period of not more than 3 months;

~~(ii)~~(b) order the respondent to receive assisted outpatient treatment pursuant to [sections 1 through 6] for a period not to exceed 12 months; or

(c) commit the respondent to a community facility~~,~~ or program~~,~~ or to any appropriate course of treatment, which may include housing or residential requirements, for a period of not more than 3 months~~;~~

~~(iii) order the respondent to be placed in the care and custody of a relative or guardian or some other appropriate place other than an institution;~~

~~(iv) order outpatient therapy; or~~

~~(v) make some other appropriate order for treatment~~.

~~(b)~~(4) ~~A~~ Except as provided in subsection (3)(b), a treatment ordered pursuant to this ~~subsection~~ section may not affect the respondent's custody or course of treatment for a period of more than 3 months.

~~(c)~~(5) In determining which of the alternatives in subsection ~~(2)(a)~~ (3) to order, the court shall choose the least restrictive alternatives necessary to protect the respondent and the public and to permit effective treatment.

(6) The court may authorize the chief medical officer of a facility or a physician designated by the court to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary to protect the respondent or the public or to facilitate effective treatment. Medication may not be involuntarily administered to a patient unless the chief medical officer of the facility or a physician designated by the court approves it prior to the beginning of the involuntary administration and unless, if possible, a medication review committee reviews it prior to the beginning of the involuntary administration or, if prior review is not possible, within 5 working days after the beginning of the involuntary

administration. The medication review committee must include at least one person who is not an employee of the facility or program. The patient and the patient's attorney or advocate, if the patient has one, must receive adequate written notice of the date, time, and place of the review and must be allowed to appear and give testimony and evidence. The involuntary administration of medication must be again reviewed by the committee 14 days and 90 days after the beginning of the involuntary administration if medication is still being involuntarily administered. The mental disabilities board of visitors and the director of the department of public health and human services must be fully informed of the matter within 5 working days after the beginning of the involuntary administration. The director shall report to the governor on an annual basis.

~~(d)~~(7) Satisfaction of any one of the criteria listed in 53-21-126(1) justifies commitment pursuant to this chapter. However, if the court relies solely upon the criterion provided in 53-21-126(1)(d), the court may require commitment only to a community facility or program or an appropriate course of treatment or to assisted outpatient treatment as provided in subsection (3)(b) or (3)(c), and may not require commitment at the state hospital.

~~(e)~~(8) In ordering commitment pursuant to this section, the court shall make the following findings of fact:

~~(i)~~(a) a detailed statement of the facts upon which the court found the respondent to be suffering from a mental disorder and requiring commitment;

~~(ii)~~(b) the alternatives for treatment that were considered;

~~(iii)~~(c) the alternatives available for treatment of the respondent;

~~(iv)~~(d) the reason that any treatment alternatives were determined to be unsuitable for the respondent;

~~(v)~~(e) the name of the facility, program, or individual to be responsible for the management and supervision of the respondent's treatment;

~~(vi)~~(f) if the order includes a requirement for inpatient treatment, the reason inpatient treatment was chosen from among other alternatives; ~~and~~

~~(vii)~~(g) if the order includes involuntary medication, the reason involuntary medication was chosen from among other alternatives; and

(h) if the order includes assisted outpatient treatment, the findings required by [section 2]."

Section 14. Section 53-21-128, MCA, is amended to read:

"**53-21-128. Petition for extension of commitment period.** (1) (a) Not less than 2 calendar weeks prior to the end of the 3-month period of commitment to the state hospital or to a community facility or program or a course of treatment provided for in 53-21-127~~(2)~~(3)(a) or (3)(c), the professional person in charge of the patient at the place of commitment may petition the district court in the county where the patient is committed for extension of the commitment period unless otherwise ordered by the original committing court. The petition must be accompanied by a written report and evaluation of the patient's mental and physical condition. The report must describe any tests and evaluation devices that have been employed in evaluating the patient, the course of treatment that was undertaken for the patient, and the future course of treatment anticipated by the professional person.

(b) Upon the filing of the petition, the court shall give written notice of the filing of the petition to the patient, the patient's next of kin, if reasonably available, the friend of respondent appointed by the court, and the patient's counsel. If any person notified requests a hearing prior to the termination of the previous commitment authority, the court shall immediately set a time and place for a hearing on a date not more than 10 days from the receipt of the request and notify the same people, including the professional person in charge of the patient. If a hearing is not requested, the court shall enter an order of commitment for a period not to exceed 6 months.

(c) Procedure on the petition for extension when a hearing has been requested must be the same in all respects as the procedure on the petition for the original 3-month commitment except the patient is not entitled to trial by jury. The hearing must be held in the district court having jurisdiction over the facility in which the patient is detained unless otherwise ordered by the court. Court costs and witness fees, if any, must be paid by the county that paid the same costs in the initial commitment proceedings.

(d) If upon the hearing the court finds the patient not to be suffering from a mental disorder and requiring commitment within the meaning of this part, the patient must be discharged and the petition dismissed. If the court finds that the patient continues to suffer from a mental disorder and to require commitment, the court shall order commitment~~, custody in relatives, outpatient therapy, or other order~~ as set forth in 53-21-127~~(2)~~(3). However, an order may not affect the patient's custody for more than 6 months unless it is a new order for assisted outpatient treatment, which may not exceed 12 months. In its order, the court shall describe what alternatives for treatment of the patient are available, what alternatives were investigated, and why the investigated alternatives were not found suitable. The court

may not order continuation of an alternative that does not include a comprehensive, individualized plan of treatment for the patient. A court order for the continuation of an alternative must include a specific finding that a comprehensive, individualized plan of treatment exists.

(2) Further extensions may be obtained under the same procedure described in subsection (1)~~;~~. ~~however~~ However, the patient's custody may not be affected for more than 1 year without a renewal of the commitment under the procedures set forth in subsection (1), including a statement of the findings required by subsection (1)."

Section 15. Section 53-21-181, MCA, is amended to read:

"53-21-181. Discharge during or at end of initial commitment period -- patient's right to referral. (1) At any time within the ~~3-month~~ period of commitment provided for in 53-21-127~~(2)~~, the patient may be discharged on the written order of the professional person in charge of ~~him~~ the patient. ~~In the event~~ If the patient is not discharged within the ~~3-month~~ period of commitment and if the term is not extended as provided for in 53-21-128, ~~he shall~~ the patient must be discharged by the facility at the end of ~~3 months~~ the period of commitment without further order of the court. Notice of the discharge ~~shall~~ must be filed with the court and the county attorney at least 5 days prior to the discharge.

(2) Upon being discharged, each patient has a right to be referred, as appropriate, to other providers of mental health services."

NEW SECTION. **Section 16. Codification instruction.** [Sections 1 through 6] are intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title 53, chapter 21, part 1, apply to [sections 1 through 6].

NEW SECTION. **Section 17. Coordination instruction.** (1) If [LC 1415] and [this act] are both passed and approved, then the bracketed references to "advanced directives" must be inserted in [this act].

(2) If [LC 1415] is not passed and approved, then the bracketed references to "advance directives" in [this act] are void.

- END -

FISCAL NOTE

Bill #: SB0466 **Title:** Revise mental health commitment laws; outpatient assisted treatment

Primary Sponsor: Mignon Waterman **Status:** As Introduced

Sponsor signature Date Chuck Swysgood, Budget Director Date

Fiscal Summary

	FY2002 Difference	FY2003 Difference
Expenditures:	0	0
Revenue:	0	0
Net Impact on General Fund Balance:	**$0**	**$0**

Yes	No		Yes	No	
	X	Significant Local Gov. Impact		X	Technical Concerns
	X	Included in the Executive Budget		X	Significant Long-Term Impacts
	X	Dedicated Revenue Form Attached		X	Family Impact Form Attached

Fiscal Analysis

ASSUMPTIONS:

1. There is no fiscal impact to the Department of Public Health and Human Services, the Department of Corrections, the Department of Justice, the Governor's Office, or the state funded Judiciary.

MINUTES

MONTANA SENATE
57th LEGISLATURE - REGULAR SESSION
COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN AL BISHOP**, on February 16, 2001 at 3 P.M., in Room 317-A Capitol.

ROLL CALL

Members Present:
Sen. Al Bishop, Chairman (R)
Sen. Duane Grimes, Vice Chairman (R)
Sen. Chris Christiaens (D)
Sen. Bob DePratu (R)
Sen. Eve Franklin (D)
Sen. Don Hargrove (R)
Sen. Dan Harrington (D)
Sen. Royal Johnson (R)
Sen. Emily Stonington (D)

Members Excused: Sen. Jerry O'Neil (R)
Sen. Fred Thomas (R)

Members Absent: None.

Staff Present: Jeanne Forrester, Committee Secretary
Susan Fox, Legislative Branch

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing(s) & Date(s) Posted: SB 459, 2/13/2001; SB 454, 2/13/2001; SB 458, 2/13/2001; SB 466, 2/13/2001
Executive Action: SB 459; SB 221; SB 341

HEARING ON SB 459

Sponsor: SEN. EVE FRANKLIN, SD 21, GREAT FALLS

Proponents: Ed Amberg, Director Warm Springs State Hospital

active treatment and it is appropriate to be provided at Warm Springs, it will be provided there, as long as they have a bed. If they do not have a bed and it is appropriate for the patient to be served at Warm Springs, they will have to find an appropriate placement in a community and the state hospital will have to pay for it.

HEARING ON SB 466

Sponsor: **SEN. MIGNON WATERMAN, SD 26, HELENA**

Proponents: **Mike Menahan, Lewis and Clark County Attorney's Office**
Dr. Gary Mihelish, National Alliance for the Mentally Ill
REP. JOHN ESP, HD 25, BIG TIMBER
Dan Anderson, DPHHS
Gene Harrin, Board of Visitors
Cindy Dahl, Great Falls

Opponents: **Anita Roessmann, Montana Advocacy Program**
Kathy Kramenbach, Virginia City
Joan Hays, Western Montana Mental Health
Charley McCarthy, Mental Health Association of Montana

Opening Statement by Sponsor:

SEN. MIGNON WATERMAN, SD 26, HELENA introduced SB 466. This is the assisted out-patient treatment bill. It is an act to revise the mental health commitment statues. It would allow the court to order assisted outpatient treatment for a period not to exceed 12 months. She passed out some information **EXHIBIT(11)**. She said this is about a category of individuals which is not very large. These people are mentally ill, but because of their illness, many times they do not realize they are ill.

{Tape : 3; Side : B; Approx. Time Counter : 0}

Proponents' Testimony:

Mike Menahan, Lewis and Clark County Attorney's Office urged the committee to consider this bill and adopt it. He said his office deals with the same people over and over. Many of these people are committed to the state hospital, put on medication, and released. Once they are out of the hospital, many of them do not take their medication and the cycle starts over again. He

thinks the intensive level of supervision at the community level will prevent re-commitment to the state hospital.

SEN. CHRISTIAENS wondered if many of these people being seen, go on to impact the corrections system. **Mr. Menahan** said that is hard to say.

Dr. Gary Mihelish, National Alliance for the Mentally Ill passed out a copy of his testimony and a copy of the *NAMI Advocate* **EXHIBIT(12)**. He said he is in support of this bill.

REP. JOHN ESP, HD 25, BIG TIMBER said he wanted to speak very briefly about what it is like to be a family member of someone who is seriously mentally ill. He said your personal life goes up and down. His sister-in-law was schizophrenic and she never knew she was. This bill will give a better quality of life to everyone involved.

Dan Anderson, DPHHS said this will be a tool to help those with mental illness.

Gene Harrin, Board of Visitors said they cautiously support this bill, as a necessary first step.

{Tape : 4; Side : A; Approx. Time Counter : 0}

Cindy Dahl, Great Falls said she is the mother of a schizophrenic son. She is worried about the future of her son. She hoped this bill would be an option to get him back in the system.

Opponents' Testimony:

Anita Roessmann, Montana Advocacy Program presented copy of her testimony **EXHIBIT(13)**.

Kathy Kramenbach, Virginia City said she is opposed to SB 466. She said she has a bipolar disorder. She felt this bill would keep her from seeking treatment because she believes this bill would leave her vulnerable to the courts.

Joan Hays, Western Montana Mental Health said she would second what the committee has heard in opposition of this bill. She does not see a need to change the community commitment laws. She said the law contains everything that is needed to form a community commitment.

Charley McCarthy, Mental Health Association of Montana said they were opposed to this bill. They would like to work with the mental health boards to come up with something better for the people.

Questions from Committee Members and Responses:

SEN. DUANE GRIMES asked if do you see other ways this bill could be crafted. **Ms. Roessman** said the criteria for the third kind of commitment could be more narrowly written. Also, she thought section two should be tightened up.

{Tape : 4; Side : B; Approx. Time Counter : 0}

SEN. GRIMES asked what is your thought on the fact that the authorities could default on this. If there is a problem individual, rather than seeking the cause, would they commit him because he is off his medication. He then asked would they have a concern about an individual being automatically committed. **Dr. Mihelish** said he did not because the protections are already in place.

Dr. Mihelish said this law is directed mostly at people who are suffering from schizophrenia and bipolar disorder.

SEN. GRIMES asked if people were not going to be treated properly and instead they would committed. **Dr. Mihelish** said 50 percent of the people with mental illnesses abuse substances; therefore, they are not complying with their treatment. The DPHHS recently initiated a study committee to try to bring the mental illness people and the chemical dependency people together, to develop an integrated program.

SEN. GRIMES asked if they would object to the application of this bill, if someone is exhibiting mental illness and is involved in frequent criminal activity. **Ms. Roessman** said no, if this bill was written narrowly enough.

SEN. CHRISTIAENS said this is a very complicated bill and he hoped it would not have to meet the transmittal date.

Closing by Sponsor:

SEN. WATERMAN thanked the committee for a good hearing. She said she had been working with **Ms. Fox** for several months on this bill. Currently, she said a person can be committed for a three month period. If they have to be recommitted, they have to go through the entire process again. This is a waste of time and

resources. She pointed out in page four, the sheriff can only be called if all other reasonable steps have been exhausted. She asked the committee not to table this bill, but to pass the bill and have them work on it and come back in two years.

EXECUTIVE ACTION ON SB 221

Discussion:

SEN. GRIMES said he would like to move to reconsider action on SB 221 for the purposes of amendments.

SEN. GRIMES explained the amendments **EXHIBIT(14) SB022108.asf.**

SEN. STONINGTON said she had some concerns about the "stand-alone" surgery centers in her community. She is also concerned about the Medicaid costs and the implications in the bill.

SEN. CHRISTIAENS wondered why the bill did not come in clean to the committee in the first place.

Motion: **SEN. GRIMES** moved **to RECONSIDER ACTION ON SB 221.**

SEN. JOHNSON said he would support the amendment.

Vote: Motion **to reconsider action on SB 221 carried 6-4 with Christiaens, Franklin, Hargrove, and Stonington voting no. SEN. THOMAS** voted by proxy.

Motion/Vote: **SEN. GRIMES** moved that **SB 221 BE AMENDED SB022108.asf. Motion carried 9-0.**

Motion/Vote: **SEN. JOHNSON** moved that **SB 221 DO PASS AS AMENDED. Motion carried 5-4 with Christiaens, Franklin, Hargrove, and Stonington voting no.**

EXECUTIVE ACTION ON SB 341

Discussion:

Ms. Fox passed out the amendments to SB 341 **EXHIBIT(15) SB034101.asf.**

The following exhibit is a folder containing an assortment of items place in the pockets or attached to the center clips, such as photo's, newspaper clippings, internet photo copies an/or of clippings of different types of visual media.

Exhibit: 11
2-16-01
SB466

The complete exhibit is located
with the minutes at the
Montana Historical Society Archives
225 North Roberts
Helena, MT 59620-1201
(406) 444-4775

The following exhibit is a folder containing an assortment of items place in the pockets or attached to the center clips, such as photo's, newspaper clippings, internet photo copies an/or of clippings of different types of visual media.

Exhibit: 12
2·16·01
SB 466

The complete exhibit is located
with the minutes at the
Montana Historical Society Archives
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Helena, MT 59620-1201
(406) 444-4775

Montana Advocacy Program

The Civil Rights Protection & Advocacy System for the State of Montana

800-245-4743 Toll-Free Voice/TDD

SENATE HEALTH & WELFARE
EXHIBIT NO. 13
DATE 2/14/01
BILL NO. SB 466

Main Office:
316 North Park Avenue, Room 211
P.O. Box 1681
Helena, Montana 59624
406-444-3889 Voice/TDD
406-444-0261 FAX
E-mail: advocate@mt.net

Missoula Office:
1280 S. 3rd Street West
Missoula, Montana 59801
406-541-4357 Voice/TDD
406-541-4360 FAX
E-mail: advocacy@marsweb.com

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John McCrea
Faun Pullin
Anita Roessmann
Pete Ruzevich
Patricia Sharp
Alexandra Volkerts
Lynn Winslow

February 16, 2001

Chairman Al Bishop and Members of the Committee
Senate Committee On Public Health, Welfare and Safety
Capitol Building
Helena, Montana 59620

RE: Senate Bill 466, Assisted Outpatient Commitment

Dear Mr. Chairman and Members of the Committee,

The Montana Advocacy Program (MAP) is a private, non-profit organization designated to protect and advocate for the rights of people with disabilities in Montana. Among those for whom we provide advocacy services are people with mental illness, particularly those in facilities.

This letter explains the impact we believe Senate Bill 466 would have in Montana, and the legal problems posed by this legislation under Montana and federal law.

To summarize, this bill creates a brand new kind of outpatient commitment, referred to as "assisted outpatient commitment," which requires the treating professional to report any "substantial noncompliance" with the court-approved outpatient treatment plan to the judge, who has several options to obtain compliance, including using law enforcement officers to bring the committed person to court or to the treatment facility. To commit a person to assisted outpatient treatment, the court must make three additional findings: that the person has recently failed to comply with a reasonable treatment plan without reasons or without adequate justification; that the person has previously been treated in an inpatient facility; and that the person lacks capacity to make rational treatment decisions. The initial assisted outpatient commitment order may be for up to 12 months, rather than limited to 3 months as under the current statute.

MAP appreciates that SB 466 is a response the anguish of family members and other supporters of a number of consumers with serious mental illness who have frequently been hospitalized after the failure of community services. However, MAP believes that SB 466 is constitutionally inadequate under the Montana constitution, and that its application would have lasting adverse effects on the community mental health system and the people it serves.

We have enumerated our concerns about this bill below.

MONTANA SENATE
2001 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 2-16-01

NAME	PRESENT	ABSENT	EXCUSED
SEN. CHRIS CHRISTIAENS	X		
SEN. BOB DEPRATU	X		
SEN. EVE FRANKLIN	X		
SEN. DON HARGROVE	X		
SEN. DAN HARRINGTON	X		
SEN. ROYAL JOHNSON	X		
SEN. JERRY O'NEIL			X
SEN. EMILY STONINGTON	X		
SEN. FRED THOMAS			X
SEN. DUANE GRIMES, VICE CHAIRMAN	X		
SEN. AL BISHOP, CHAIRMAN	X		

SEN:1997
wp.rollcall.man
CS-09

MINUTES

MONTANA SENATE
57th LEGISLATURE - REGULAR SESSION
COMMITTEE ON PUBLIC HEALTH, WELFARE AND SAFETY

Call to Order: By **CHAIRMAN AL BISHOP**, on March 14, 2001 at 3:15 P.M., in Room 335 Capitol.

ROLL CALL

Members Present:

Sen. Al Bishop, Chairman (R)
Sen. Duane Grimes, Vice Chairman (R)
Sen. Chris Christiaens (D)
Sen. Bob DePratu (R)
Sen. Eve Franklin (D)
Sen. Don Hargrove (R)
Sen. Dan Harrington (D)
Sen. Royal Johnson (R)
Sen. Jerry O'Neil (R)
Sen. Emily Stonington (D)

Members Excused: Sen. Fred Thomas (R)

Members Absent: None.

Staff Present: Jeanne Forrester, Committee Secretary
Susan Fox, Legislative Branch

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted:
Executive Action: HB 279; HB 583; SB 466

EXECUTIVE ACTION ON HB 279

Motion: SEN. ROYAL JOHNSON moved that **HB 279 BE AMENDED EXHIBIT(phs58a01) HB027901.asf.**

Discussion:

SEN. GRIMES asked if it would be too late to appoint a subcommittee.

SEN. HARGROVE said we should not throw away this bill, because it is too important.

SEN. CHRISTIAENS withdrew his substitute motion.

SEN. STONINGTON withdrew her motion.

SEN. BISHOP appointed a subcommittee - **SEN. GRIMES AS CHAIRMAN, SEN. FRANKLIN,** and **SEN. O'NEIL.**

SEN. GRIMES said the subcommittee will meet on Monday, March 19, 2001.

EXECUTIVE ACTION ON SB 466

Motion: **SEN. CHRISTIAENS** moved that **SB 466 BE AMENDED EXHIBIT(4) SB046601.asf.**

Discussion:

Ms. Fox explained the amendments and passed out a copy of the present law, 53-21-126, **EXHIBIT(5)**, which has to do with amendment 19.

SEN. FRANKLIN said a professional person and a mental health professional person are not the same thing. **Ms. Fox** said a mental health professional person can be added if the committee so desires.

{Tape : 2; Side : A; Approx. Time Counter : 0}

Vote: Motion that **SB 466 BE AMENDED carried 10-0.**

SEN. CHRISTIAENS Moved **SB 466 AS AMENDED.**

SEN. FRANKLIN expressed concern about New Section 2, page 1; a person could be classified as a non-compliant person if you were hospitalized one time in your life.

SEN. GRIMES said he has an amendment **EXHIBIT(6) SB046602.asf** and he explained his amendment.

SEN. FRANKLIN said we have to allow the process to take place by which some people will recognize they have an illness. We cannot have a person hospitalized one time and have them categorized as a non-compliant person.

Motion: **SEN. GRIMES** moved that **SB 466 BE AMENDED SB046602.asf.**

Ms. Fox said there are two other places in the bill, that refer back to Section 53-21-126, which has to do with non-compliance. She also said the logic of intent of assisted out-patient treatment, is to keep people on track for treatment.

SEN. GRIMES said as far as he is concerned, he would not want to replace the other two references in the bill. He felt they would keep the bill consistent.

Ms. Roessman said she thought the amendment **SEN. GRIMES** had proposed was an improvement.

Vote: Motion that **SB 466 BE AMENDED, SB046602.asf, carried 8-0.**

SEN. FRANKLIN said she had a verbal amendment - to New Section 2. She would like to insert:

a) the respondent has experienced two prior civil commitments.

b) that for at least one recent extended period the respondent failed to follow a reasonable treatment plan.

She said that would make it "three strikes and you're out (or in)".

Motion/Vote: **SEN. FRANKLIN** moved **HER VERBAL AMENDMENT TO SB 466. Motion carried 8-0.**

Motion/Vote: **SEN. CHRISTIAENS** moved that **SB 466 DO PASS AS AMENDED. Motion carried 8-2 with DePratu and Grimes voting no. SEN. STONINGTON** voted by proxy.

{Tape : 2; Side : B; Approx. Time Counter : 0}

SENATE HEALTH & WELFARE
EXHIBIT NO. 4
DATE 3-14-01
BILL NO. SB 466

Amendments to Senate Bill No. 466
1st Reading Copy

Requested by Senator Mignon Waterman

For the Senate Public Health, Welfare and Safety Committee

Prepared by Susan Byorth Fox
March 12, 2001 (2:13PM)

1. Title, line 11.
Following: "DIVERSION;"
Insert: "DEFINING "MENTAL HEALTH PROFESSIONAL"; ALLOWING FOR AN EXTENSION OF THE ASSISTED OUTPATIENT TREATMENT AT THE REQUEST OF THE RESPONDENT;"
Following: "46-16-130,"
Insert: "53-21-102,"

2. Page 1, line 20.
Following: "plan"
Insert: "developed pursuant to [section 3]"

3. Page 1, line 21.
Strike: "or"
Following: "treatment,"
Insert: "assertive community treatment, or a combination,"

4. Page 2, line 8.
Following: "means a"
Insert: "well-reasoned, willful, and knowing"

5. Page 2, line 9.
Following: "reasons"
Insert: "concerning medical or psychiatric treatment"

6. Page 2, line 10.
Following: "recommendation of a"
Insert: "mental health"
Following: "professional"
Strike: "person"

7. Page 2, line 11.
Strike: "professional person's"
Insert: "mental health professional's"

8. Page 2, line 13.
Following: "reasonable"
Insert: "written"
Following: "plan"
Insert: "that follows accepted medical standards, is supervised by a mental health professional, and does not result in one of the conditions in 53-21-126(1)"

9. Page 2, line 14.
Following: "(3)"
Insert: "(a)"

10. Page 2, line 16.
Following: "other"
Insert: "mental health"
Following: "professional"
Strike: "person"

11. Page 2, line 18.
Following: line 17
Insert: "(b)(i)"

12. Page 2, line 22.
Following: "others."
Insert: "(ii) If the respondent has been previously ordered to assisted outpatient treatment and the respondent has requested an extension as provided in 53-21-128, the court may, in the absence of evidence to the contrary, consider that the presumption that the respondent has the capacity to make rational treatment decisions has been overcome."

13. Page 3, line 3.
Following: "family"
Insert: ", if family involvement is determined by the court in consultation with the mental health professional to be in the best interests of the respondent,"

14. Page 3, line 17 through line 18.
Following: "decisions" on line 17
Strike: remainder of line 17 through "1415]" on line 18

15. Page 3, line 20.
Strike: "[or in the advance directive]"

16. Page 3, line 22.
Strike: "[or an advance directive]"

17. Page 3, line 30.
Following: "appearance"
Insert: "or at any time during the commitment"

18. Page 4, line 5.
Strike: "in a timely manner"
Insert: "at each 3-month court appearance"

19. Page 4, line 14.
Following: "noncompliance"
Insert: "that is likely to result in at least one of the conditions in 53-21-126(1)"

20. Page 5, line 5.
Following: "treatment"
Strike: "if the individual under the commitment"
Insert: ". However, nothing in this chapter obligates the department to pay for services ordered under 53-21-127 unless the respondent"

21. Page 5, line 6.
Following: "system"
Insert: "funded by the department, the service is one that the department has included in its mental health program, and the department determines that the mental health service is medically necessary for the respondent"

22. Page 6, line 3.
Following: line 2
Insert: "Section 8. Section 53-21-102, MCA, is amended to read:

"53-21-102. Definitions. As used in this part, the following definitions apply:

(1) "Board" or "mental disabilities board of visitors" means the mental disabilities board of visitors created by 2-15-211.

(2) "Commitment" means an order by a court requiring an individual to receive treatment for a mental disorder.

(3) "Court" means any district court of the state of Montana.

(4) "Department" means the department of public health and human services provided for in 2-15-2201.

(5) "Emergency situation" means a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment.

(6) "Friend of respondent" means any person willing and able to assist a person suffering from a mental disorder and requiring commitment or person alleged to be suffering from a mental disorder and requiring commitment in dealing with legal proceedings, including consultation with legal counsel and others. The friend of respondent may be the next of kin, the person's conservator or legal guardian, if any, representatives of a charitable or religious organization, or any other person appointed by the court to perform the functions of a friend of respondent set out in this part. Only one person may at any one time be the friend of respondent within the meaning of this part. In appointing a friend of respondent, the court shall consider the preference of the respondent. The court may at any time, for good cause, change its designation of the friend of respondent.

(7) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The term does not include:

(a) addiction to drugs or alcohol;

(b) drug or alcohol intoxication;

(c) mental retardation; or

(d) epilepsy.

(8) "Mental health facility" or "facility" means a public hospital or a licensed private hospital that is equipped and staffed to provide treatment for persons with mental disorders or a community mental health center or any mental health clinic or treatment center approved by the department. A correctional institution or facility or jail is not a mental health facility within the meaning of this part.

(9) "Mental health professional" means:

(a) a certified professional person;

(b) a physician licensed under Title 37, chapter 3;

(c) a professional counselor licensed under Title 37, chapter 23;

(d) a psychologist licensed under Title 37, chapter 17; or

(e) a social worker licensed under Title 37, chapter 22.

~~(9)~~(10) "Next of kin" includes but is not limited to the spouse, parents, adult children, and adult brothers and sisters of a person.

~~(10)~~(11) "Patient" means a person committed by the court for treatment for any period of time or who is voluntarily admitted for treatment for any period of time.

~~(11)~~(12) "Peace officer" means any sheriff, deputy sheriff,

marshal, police officer, or other peace officer.

~~(12)~~(13) "Professional person" means:

(a) a medical doctor; or

(b) a person who has been certified, as provided for in 53-21-106, by the department.

~~(13)~~(14) "Reasonable medical certainty" means reasonable certainty as judged by the standards of a professional person.

~~(14)~~(15) "Respondent" means a person alleged in a petition filed pursuant to this part to be suffering from a mental disorder and requiring commitment.

~~(15)~~(16) "State hospital" means the Montana state hospital."

{Internal References to 53-21-102:

41-5-1504 x	*41-5-1504 x*	*41-5-1504x*	*41-5-1512 x*
41-5-1512 x	*45-5-206 x*	*53-20-130x*	*53-21-105 x*
53-21-106 x	*53-21-106x*	*53-21-138x*	*53-21-411 x*
53-21-601 x	*72-5-408x*	*72-5-415 x}"*	

Renumber: subsequent sections

23. Page 11, line 18.
Following: "testimony"
Insert: "regarding the findings of fact required in [section 2]"

24. Page 11, line 25.
Following: "decisions"
Insert: "as defined in [section 2]"

25. Page 15, line 4.
Following: line 3
Insert: "(2) Prior to the end of the 12-month period of commitment to assisted outpatient treatment as provided in 53-21-127(3)(b), a respondent may request that the treating provider petition the district court for an extension of the assisted outpatient treatment order. The petition must be accompanied by a written report and evaluation of the respondent's mental and physical condition, an updated treatment plan, and a written statement by the respondent that an extension of assisted outpatient treatment is desired. The extension procedure must follow the procedure required in subsections (1)(b) through (1)(d)."
Renumber: subsequent subsection

26. Page 15, line 4.
Following: "extensions"
Insert: "under subsection (1) or (2)"

53-21-125. Request for jury trial. At any time prior to the date set for hearing, the respondent, through his counsel, may request a jury trial, whereupon the time set for hearing shall be vacated and the matter set on the court's jury calendar at the earliest date possible, the matter taking precedence over all other matters. If there is not a jury in attendance, a jury shall be selected in the manner provided in 3-15-506 and a date set for trial by jury not later than 7 days, exclusive of Saturdays, Sundays, and holidays.

History: En. 38-1305 by Sec. 5, Ch. 486, L. 1975; amd. Sec. 5, Ch. 546, L. 1977; R.C.M. 1947, 38-1305(part).

Cross-References

Due process of law, Art. II, sec. 17, Mont. Const.

53-21-126. Trial or hearing on petition. (1) The respondent must be present unless the respondent's presence has been waived as provided in 53-21-119(2), and the respondent must be represented by counsel at all stages of the trial. The trial must be limited to the determination of whether or not the respondent is suffering from a mental disorder and requires commitment. At the trial, the court shall consider all the facts relevant to the issues of whether the respondent is suffering from a mental disorder. If the court determines that the respondent is suffering from a mental disorder, the court shall then determine whether the respondent requires commitment. In determining whether the respondent requires commitment, the court shall consider the following:

(a) whether the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) whether the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) whether, because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; and

(d) whether the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(2) The standard of proof in a hearing held pursuant to this section is proof beyond a reasonable doubt with respect to any physical facts or evidence and clear and convincing evidence as to all other matters. However, the respondent's mental disorder must be proved to a reasonable medical certainty. Imminent threat of self-inflicted injury or injury to others must be proved by overt acts or omissions, sufficiently recent in time as to be material and relevant as to the respondent's present condition.

(3) The professional person appointed by the court must be present for the trial and subject to cross-examination. The trial is governed by the Montana Rules of Civil Procedure. However, if the issues are tried by a jury, at least two-thirds of the jurors shall concur on a finding that the respondent is suffering from a mental disorder and requires commitment. The written report

SENATE HEALTH & WELFARE
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of the professional person that indicates the professional person's diagnosis may be attached to the petition, but any matter otherwise inadmissible, such as hearsay matter, is not admissible merely because it is contained in the report. The court may order the trial closed to the public for the protection of the respondent.

(4) The professional person may testify as to the ultimate issue of whether the respondent is suffering from a mental disorder and requires commitment. This testimony is insufficient unless accompanied by evidence from the professional person or others that:

(a) the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; or

(d) (i) the respondent's mental disorder:

(A) has resulted in recent acts, omissions, or behaviors that create difficulty in protecting the respondent's life or health;

(B) is treatable, with a reasonable prospect of success;

(C) has resulted in the respondent's refusing or being unable to consent to voluntary admission for treatment; and

(ii) will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(5) The court, upon the showing of good cause and when it is in the best interests of the respondent, may order a change of venue.

History: En. 38-1305 by Sec. 5, Ch. 486, L. 1975; amd. Sec. 5, Ch. 546, L. 1977; R.C.M. 1947, 38-1305(part); amd. Sec. 8, Ch. 547, L. 1979; amd. Sec. 9, Ch. 376, L. 1987; amd. Sec. 22, Ch. 488, L. 1997.

Cross-References

Montana Rules of Civil Procedure, Title 25, ch. 20.

53-21-127. Posttrial disposition. (1) If, upon trial, it is determined that the respondent is not suffering from a mental disorder or does not require commitment within the meaning of this part, the respondent must be discharged and the petition dismissed.

(2) (a) If it is determined that the respondent is suffering from a mental disorder and requires commitment within the meaning of this part, the court shall hold a posttrial disposition hearing. The disposition hearing must be held within 5 days (including Saturdays, Sundays, and holidays unless the fifth day falls on a Saturday, Sunday, or holiday), during which time the court may order further evaluation and treatment of the respondent. At the conclusion of the disposition hearing, the court shall:

(i) commit the respondent to the state hospital for a period of not more than 3 months;

SENATE HEALTH & WELFARE
EXHIBIT NO. 6
DATE 3-14-01
BILL NO. SB 466

Amendments to Senate Bill No. 466
1st Reading Copy

Requested by Senator Duane Grimes

For the Senate Public Health, Welfare and Safety Committee

Prepared by Susan Byorth Fox
March 14, 2001 (3:00PM)

1. Page 2, line 2.
Following: "53-21-126(1)"
Insert: "(b) or (c)"

- END -

37

MONTANA SENATE
2001 LEGISLATURE
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE

ROLL CALL DATE 3-14-01

NAME	PRESENT	ABSENT	EXCUSED
SEN. CHRIS CHRISTIAENS	X		
SEN. BOB DEPRATU	X		
SEN. EVE FRANKLIN	X		
SEN. DON HARGROVE	X		
SEN. DAN HARRINGTON	X		
SEN. ROYAL JOHNSON	X		
SEN. JERRY O'NEIL	X		
SEN. EMILY STONINGTON	X		
SEN. FRED THOMAS			X
SEN. DUANE GRIMES, VICE CHAIRMAN	X		
SEN. AL BISHOP, CHAIRMAN	X		

SEN:1997
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MINUTES

MONTANA HOUSE OF REPRESENTATIVES
57th LEGISLATURE - REGULAR SESSION
COMMITTEE ON HUMAN SERVICES

Call to Order: By **CHAIRMAN BILL THOMAS**, on March 26, 2001 at 3:00 P.M., in Room 172 Capitol.

ROLL CALL

Members Present:

Rep. Bill Thomas, Chairman (R)
Rep. Roy Brown, Vice Chairman (R)
Rep. Trudi Schmidt, Vice Chairman (D)
Rep. Tom Dell (D)
Rep. John Esp (R)
Rep. Tom Facey (D)
Rep. Daniel Fuchs (R)
Rep. Dennis Himmelberger (R)
Rep. Larry Jent (D)
Rep. Michelle Lee (D)
Rep. Brad Newman (D)
Rep. Mark Noennig (R)
Rep. Holly Raser (D)
Rep. Diane Rice (R)
Rep. Rick Ripley (R)
Rep. Clarice Schrumpf (R)
Rep. Jim Shockley (R)
Rep. James Whitaker (R)

Members Excused: None.

Members Absent: None.

Staff Present: David Niss, Legislative Branch
Pati O'Reilly, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing(s) & Date(s) Posted: SB 315, SB 461, SB 473, SB 454 SB 466, 3/22/2001
Executive Action: SB 329, SB 420, SB 477, SB 248, SB 454, SB 473, SB 315, SB 461, SB 466

EXECUTIVE ACTION ON SB 329

Christie Blazer, Childrens Comprehensive Services. We support this bill. ***{Tape : 2; Side : B; Approx. Time Counter : 20 - 20.6}***

Mike Ferritter, Dept of Corrections. ***{Tape : 2; Side : B; Approx. Time Counter : 20.6 - 20.8}***

Al Davis, Mental Health Assn. We support this bill. ***{Tape : 2; Side : B; Approx. Time Counter : 20.8 - 20.9}***

Gene Haire, Board of Visitors. We support this bill. ***{Tape : 2; Side : B; Approx. Time Counter : 20.9 - 21.1}***

Bonnie Adee, Ombudsman, Governors Office. We support the bill. ***{Tape : 2; Side : B; Approx. Time Counter : 21.1- 21.3}***

Opponents' Testimony: None

Questions from Committee Members and Responses: **Rep. Facey: Sen. Waterman**, Page 3, section 3, states any health provider can participate in this authority. Is there any notice provision for the small players. **Sen. Waterman:** It is our intention that all providers be notified. The Dept. will do that and offer everyone a seat at the table.

Rep. Brown: Sen. Waterman, The fiscal note states technical concerns about coordination with Title 52, has that been resolved? **Sen. Waterman:** Yes, I think it has.

Rep. Rice: Sen. Waterman, Could you describe the top five clients on this list, what is the care they receive and seriousness of their illness? **Sen. Waterman:** These top three are in residential placements, they may be out of state in an intensive facility. They probably are a danger to themselves or others and been in the system for sometime. They are involved in several other systems. **Rep. Rice:** Is the costs here for more than mental health care? **Sen. Waterman**, No, this is just the mental health care costs. **Rep. Rice: Dan Anderson**, Same question. **Dan Anderson:** I think Sen Waterman gave a good answer. These are out of control children requiring 24 hour a day care. They probably have other problems, etc. ***{Tape : 2; Side : B; Approx. Time Counter : 22 - 30} {Tape : 3; Side : A; Approx. Time Counter : 0 - 0.2}***

Closing by Sponsor: **Sen. Waterman** closed. ***{Tape : 3; Side : A; Approx. Time Counter : 0.2 - 0.4}***

HEARING ON SB 466

Sponsor: Sen. Waterman, SD 26

Proponents: **Dr. Gary Mihelish, Natl Assn for Mentally Ill**
Gene Haire, Board of Visitors
Don Anderson, DPPHS
Jerry Marble, Missoula Citizen

Opponents: **Bernadette Franks-Ongoy, Advocacy Program**
Colleen Murphy, MT Society of Social Workers
Chris Marsh, Western Montana Mental Health Center

Opening Statement by Sponsor: **Sen. Waterman**, this is a very important piece of legislation that deals with extended community involuntary commitments and is a highly controversial. I am passing out several articles that describe assisted out patient treatment. Admissions to hospital decreased and length decreased. This bill deals with adults in the system. People who have serious long term mental illness, in and out of hospitals on several occasions. Individuals must receive treatment long enough to become stable and there must be a consequence for not following the treatment plan. **EXHIBIT(9) EXHIBIT(10)EXHIBIT(11) EXHIBIT(12)** ***{Tape : 3; Side : A; Approx. Time Counter : 0.4 - 10.2}***

Proponents' Testimony: **Dr. Gary Mihelish**, Natl Alliance for the Mentally Ill. We are a large organization of mentally ill patients and their family members. We believe that all patients should make their own decisions regarding treatment, however there are some who are to sick to make these decisions. Out patient treatment would be less expensive, closer to home and allow family members to be involved. This assisted outpatient treatment is better than homelessness, premature death, or incarceration. ***{Tape : 3; Side : A; Approx. Time Counter : 10.2 - 17}***

Dan Anderson, DPPHS, We support this bill and agree with the previous testimony. ***{Tape : 3; Side : A; Approx. Time Counter : 17 - 17.1}***

Gene Haire, Mental Disabilities Board of Visitors: This bill will help with involuntary commitment. ***{Tape : 3; Side : A; Approx. Time Counter : 17.1 - 17.4}***

Jerry Marble, Missoula Citizen. I support this bill because my wife committed suicide and I was unable to help her and found it almost impossible to commit her. This was her fourth attempt and I could not get her committed. This bill adds more leverage in getting help with suicidal patients. ***{Tape : 3; Side : A; Approx. Time Counter : 17.4 - 20.6}***

Opponents' Testimony: **Bernadette Franks-Ongoy, Ex. Director of the Montana Advocacy Program.** We oppose this bill, I have a chart that shows the present commitment laws that I believe are adequate. I understand, the need to do something for people to get mental health treatment. However, I understand the constitutional rights of citizens. We do not need this bill. ***{Tape : 3; Side : A; Approx. Time Counter : 22.6 - 26.4}***

Colleen Murphy, Natl Assn of Social Workers. I represent the clinicians. We do not need this legislation. ***{Tape : 3; Side : A; Approx. Time Counter : 26.4 - 30} {Tape : 3; Side : B; Approx. Time Counter : 0 - 2.4}***

Chris Marsh, Western Montana Mental Health Center. We support this legislation. **EXHIBIT(13)** ***{Tape : 3; Side : B; Approx. Time Counter : 2.4 - 3}***

Questions from Committee Members and Responses: **Rep. Newman; Sen. Waterman,** Page 2, line 8, a person must have two other civil commitments. How is a prosecutor to know about these previous commitments, as all commitments are confidential? **Sen. Waterman,** I think you probably would not know, unless the provider supplied that information. This is a narrow scope of people. **Rep. Newman:** Don't our commitment laws allow this type of procedure? **Sen. Waterman:** Yes, you can. This is for a very specific population. The 3 month threshold is very frustrating to law enforcement. **Rep. Newman:** The law already allows an extension of the 3 months? **Sen. Waterman:** Yes. **Rep. Newman:** In cases of commitment to the State hospital can't we conditionally discharge the patients? **Sen. Waterman:** Yes, up to two years of time. **Rep. Newman:** One of the proponents indicated the legal hoops may be more restrictive than what we have now. **Sen. Waterman:** I don't believe so.

Rep. Noennig: Sen. Waterman, Section 3 on page 3 has some strange things that I don't understand. Reference to a directive, etc. Is that a mistake or is it intentional. Please explain. **Sen. Waterman,** that refers to a bill Esp is carrying and if it passes these two bills can be combined or at least non conflicting. **Rep. Noennig:** I disagree with the parties named that can make the decision for commitment. I do not believe that Power of Attorney will allow this. **Sen. Waterman:** I think there is a Power of Attorney that allows this. **Rep. Noennig:** I do not agree with the persons listed and will oppose some of these from making decisions on healthcare.

Rep. Facey: Sen. Waterman, did you look at the Montana ethics that was passed out. MT law already have these powers? **Sen. Waterman:**

This bill would make the courts act on these cases and the DPPHS would be mandated to fund the program. ***{Tape : 3; Side : B; Approx. Time Counter : 3 - 17.4}***

Closing by Sponsor: Sen. Waterman closed SB 466. She gave a general wrap up of the discussion. ***{Tape : 3; Side : B; Approx. Time Counter : 17.4 - 22.1}***

EXECUTIVE ACTION ON SB 420

Motion: **REP. LEE** moved that **SB 420 BE CONCURRED IN.**

Discussion: **Rep. Lee** is concerned if there is anything in the bill that calls for action after this bill is passed.

Motion/Vote: **REP. LEE** moved that **SB 420 BE CONCURRED IN. Motion carried unanimously.** Rep. Facey to carry on house floor.***{Tape : 3; Side : B; Approx. Time Counter : 22.1 - 26.9}***

EXECUTIVE ACTION ON SB 477

Motion: **REP. ESP** moved that **SB 477 BE CONCURRED IN. EXHIBIT(14) EXHIBIT(15) EXHIBIT(16)*{Tape : 3; Side : B; Approx. Time Counter : 26.9 - 30}***

Motion: **REP. ESP** moved that **SB 477 BE AMENDED.**

Discussion: **Staffer Ness**: This amendment adds APRN's to list of persons who can order the use of the safety device. **Rep. Noennig:** We had a sub-committee meeting on this bill this morning, we did not discuss this amendment. We are worried about the federal regulations and this bill having a conflict with federal regulations. Does the federal reference to physician include or exclude APRNs. **Ness:** I don't know. **Rep. Jent**: What about PA and Nurse Practitioners? Guess, I don't know the answers either. **Rep. Shockley**: If we don't know what the law is, lets don't mess with this, I recommend we vote no on this amendment. **Rep. Raser**: I think that to the extend allowed by law, APRN's should be allowed to make these decisions. If this is a problem we need to look at it. I think we should vote for the amendment. **Rep. Lee**: Could we put it in there so it is other medical professionals? **Rep. Shockley:** It is late and we should not pass laws that we do not know what they mean. We are saying if it is okay with federal government, it is okay with us. If we don't know-we should not pass the law. **Rep. Schrump**: Can we ask Rose Hughes? **Rose Hughes**, the nursing association asked us and we felt it was an appropriate amendment. There are federal statutes give APRN and NP the ability to step in for doctors. We do not have an answer as to the

EXECUTIVE ACTION ON SB 466

Motion: REP. HIMMELBERGER moved that **SB 466 BE CONCURRED IN.**

Discussion: Rep. Esp: My concerns come from the family side and I thinks we need to have the ability to commit family members. If the current law address the medication and danger issues, maybe we don't need this bill, but if current law does not say this, then we need some portions of this bill. Families have to make the decision to take action and ask for commitment, etc. and usually it is unsuccessful. **Rep Newman**: This bill is absolutely unnecessary, they can do everything this bill calls at this time. We now have the authority to extend a commitment longer than 90 days. **Rep. Brown**: Dr. Mihelish states the NAMI, a highly respected association, is in support of this bill. I am going to support this bill. **Rep. Esp.** shared the story of his family member and their need for this bill. The attorneys and judges used the law as it was in 1998 they were not using this section as **Rep. Newman** described. I don't know why but they did not and the family goes through a life of Hell and no one can help at this time. I am a family member and have lived through this scenario and it happens two or three times a year. Maybe education would help, but with no solution, you make a trip to the morgue and that is no fun. The quality of life would be improved if they had a longer 12 month commitment to stay on their meds and try to stay healthy. A better system is needed where the provider is responsible to intervene and monitor. **Rep. Newman**, I don't view this as a way of living and I live with a manic depressive Mother and see this all of the time. I don't want to fight about this and I realize Rep. Esp's feeling are real. This is an illness that affects my family, but these decisions are hard to make and hurt the family. The law already allows for intervention.

Motion/Vote: **REP. NOENNIG** moved that **SB 466 BE AMENDED. Motion carried unanimously.** This was a conceptual amendment. **Motion carried unanimously.**

Motion/Vote: **REP. FACEY** moved that **SB 466 BE CONCURRED IN AS AMENDED. Motion carried 17-1 with Newman voting no.** Rep. Esp to carry on the house floor. ***{Tape : 5; Side : A; Approx. Time Counter : 24.6 - 30} {Tape : 5; Side : B; Approx. Time Counter : 0 - 27.7}***

E409
3/26/01
SB 406

Cheri Asay
353 Prospectors Lane
Billings, MT 59105
406-245-4798

Senator Mingnon Waterman
c/o post office Box 200500
Helena, Mt. 59620

January 15, 2001

Dear Senator Waterman:

It has been brought to our attention that the community commitment for the mentally ill no longer exists. We would like you to try to reinstate it. With many of us being self-injurers, the legal threat of a lengthy placement in a more restrictive environment encourages us to reconsider engaging in this type of behavior thus reducing episodes. Ultimately, this helps Montana to retain its medical resources because short-term psychiatric hospitalization is almost always the result of this behavior.

Sincerely,

Cheri R. Asay

Cheri Asay &
Other consumers who wish to remain anonymous
(phone #'s available on request)

Dear Senator M. Wellstone,

01-18-01

Just a short note ~~regaur~~ regarding my specific problem. I hurt myself by cutting on myself. When I have a community commitment on me – I think twice & then usually not go ahead with hurting myself. Without a C.C. I feel – whats the difference – it doesn't matter. And I usually hurt myself ~ 2x month, on an average. Let me know if there's any other information I can help with

Sincerely

Cheri R. Hay

Exhibit 3/26/01 SB466

from: Mignon Waterma & Dr. Gary Mihelish

Briefing Paper

Assisted Outpatient Treatment Reduces Hospital Stays, Violence And Improves Odds of Recovery for People with Severe Mental Illnesses

Approximately 40 percent of all individuals with severe mental illnesses (i.e. schizophrenia and manic-depressive illness) are not receiving treatment at any given time.[1] Many of these individuals are homeless, in jail on misdemeanor charges, and responsible for increasing episodes of violence.[2] A major reason why so many severely psychiatrically ill individuals are not being treated is that, because of the effects of the illness on their brain, they lack awareness of their illness. Studies have shown that approximately half of all patients with schizophrenia[3] and mania[4] have markedly impaired awareness of their illness as measured by tests of insight; thus, they are similar to some patients with cerebrovascular accidents (strokes) and with Alzheimer's disease. Such individuals consistently refuse to take medication because they do not believe they are sick. In most cases, they will take medication only under some form of assisted treatment.

Forty-one states use a form of assisted treatment commonly referred to as outpatient commitment, also called assisted outpatient treatment.[5] Assisted outpatient treatment involves court ordered treatment (including medication) as a condition of remaining in the community for individuals who have a history of medication non-compliance. Typically, violation of the court ordered conditions can result in the individual being hospitalized for further treatment.

Long-term assisted outpatient treatment (LT-AOT) combined with routine outpatient services (3 or more outpatient visits per month) has been shown to be significantly more effective in reducing violence and improving outcomes for severely mentally ill individuals than routine outpatient care without LT-AOT. Results from a North Carolina study [6] showed a 36% reduction in violence among severely mentally ill individuals in long-term assisted outpatient treatment (LT-AOT - 180 days or more) compared to individuals receiving less than LT-AOT (0 to 179 days). Among a group of individuals characterized as seriously violent (i.e. committed violent acts within the 4 month period prior to the study), 63.3% of those not in LT-AOT repeated violent acts while only 37.5% of those in LT-AOT did so. LT-AOT combined with routine outpatient services reduced the predicted probability of violence by 50%.

In another report from the North Carolina study,[7] LT-AOT reduced hospital admissions by 57% and length of hospital stay by 20 days compared to individuals without court ordered treatment. The results were even more dramatic for individuals with schizophrenia and other psychotic disorders for whom LT-AOT reduced hospital admissions by 72% and length of hospital stay by 28 days compared to individuals without court ordered treatment.

The effectiveness of assisted outpatient treatment in decreasing hospital admissions has been clearly established in several studies. In Washington, D.C., admissions decreased from 1.81 per year to 0.95 per year before and after outpatient commitment.[8] Similarly, in Ohio the decrease was from 1.5 to 0.4[9] and in Iowa from 1.3 to 0.3.[10] In North Carolina, admissions for patients on outpatient commitment decreased from 3.7 to 0.7 per 1,000 days.[11] Only two studies have failed to definitively find assisted outpatient treatment effective in reducing

admissions. One was a Tennessee study in which it was evident that "outpatient clinics are not vigorously enforcing the law" and thus non-adherence had no consequences.[12] The second was a study in New York in which the authors acknowledged that a "limit on [the study's] ability to draw wide-ranging conclusions is the modest size of [the] study group."[13] Additionally, during the period of the study, there was no procedure in place to transport individuals who did not comply with treatment orders to the hospital for evaluation. As in the Tennessee study, non-adherence to a treatment order had no consequences. Although not statistically significant, the New York study suggests that the court orders did in fact help reduce the need for hospitalization. Patients in the court-ordered group spent a median of 43 days in the hospital during the study year, while patients in the control group spent a median of 101 days in the hospital. The difference in fact just misses statistical significance at the level of p = 0.05.

Outpatient commitment has also been shown to be effective as a form of assisted treatment in increasing treatment compliance. In North Carolina only 30 percent of patients on outpatient commitment refused medication during a six-month period compared to 66 percent of patients not on outpatient commitment.[14] In Ohio, outpatient commitment increased patients' compliance with outpatient psychiatric appointments from 5.7 to 13.0 per year and with attendance at day treatment sessions from 23 to 60 per year.[15] In Arizona, among patients who had been outpatient committed "71 percent of the patients voluntarily maintained treatment contacts six months after their orders expired" compared to "almost no patients" who had not been put on outpatient commitment.[16] And in Iowa "it appears as though outpatient commitment promotes treatment compliance in about 80 percent of patients while they are on outpatient commitment. After commitment is terminated about three-quarters of that group remain in treatment on a voluntary basis."[17]

Endnotes:

[1]Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., Goodwin, F.K. The de facto US Mental and Addictive Disorders Service System: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, 50:85–94 (1993).

[2]Torrey, E.F. *Out of the Shadows: Confronting America's Mental Illness Crisis*, (John Wiley and Sons, 1997).

[3]Amador, X.F., Strauss, D.H., Yale, S.A., and Gorman, J.M. Awareness of illness in schizophrenia. *Schizophrenia Bulletin*, 17:113–132 (1991).

[4]Ghaemi, S.N. Insight and psychiatric disorders: a review of the literature, with a focus on its clinical relevance for bipolar disorder. *Psychiatric Annals*, 27:782–790 (1997).

[5]Torrey, E.F. and Kaplan, R.J. A national survey of the use of outpatient commitment. *Psychiatric Services*, 46:778–784 (1995).

[6]Swanson, J.W., Swartz, M.S., Borum, R. et al. Involuntary out-patient commitment and reduction of violent behaviour in persons with severe mental illness. *British Journal of Psychiatry*,176: 224–231 (2000).

[7]Swartz, M.S., Swanson, J.W., Wagner, R.H., et al. Can involuntary Outpatient commitment reduce Hospital Recidivism? *American Journal of Psychiatry*, 156:1968-1975 (1999).

[8]Zanni, G. and deVeau, L. Inpatient stays before and after outpatient commitment. *Hospital and Community Psychiatry* 37:941–942 (1986).

[9]Munetz, M.R., Grande, T., Kleist, J., and Peterson, G.A. The effectiveness of outpatient civil commitment. *Psychiatric Services*, 47:1251–1253 (1996).

[10]Rohland, B.M. The role of outpatient commitment in the management of persons with schizophrenia. Iowa Consortium for Mental Health, Services, Training, and Research (May 1998).

[11]Fernandez, G.A. and Nygard, S. Impact of involuntary outpatient commitment on the revolving-door syndrome in North Carolina. *Hospital and Community Psychiatry* 41:1001–1004 (1990).

[12]Bursten B. Posthospital mandatory outpatient treatment. *American Journal of Psychiatry* 143:1255–1258 (1986).

[13]Research study of the New York City involuntary outpatient commitment pilot program. Policy Research Associates, Inc. (December 1998).

[14]Hiday, V.A. and Scheid-Cook, T.L. The North Carolina experience with outpatient commitment: a critical appraisal. *International Journal of Law and Psychiatry*, 10:215–232 (1987).

[15]Munetz, *supra* note 8.

[16]Van Putten, R.A., Santiago, J.M., Berren, M.R. Involuntary outpatient commitment in Arizona: a retrospective study. *Hospital and Community Psychiatry* 39:953–958 (1988).

[17]Rohland, *supra* note 9.

EH 11
3/26/01
LB 466

TUESDAY, AUGUST 1, 2000 R DM VA

The Washington Post

AN INDEPENDENT NEWSPAPER

E. Fuller Torrey and Mary T. Zdanowicz

Let Us Treat Them Now

Run this by us again. A U.S. District judge is considering whether Russell Weston, a man suffering from paranoid schizophrenia and who allegedly killed two Capitol Police officers, can be involuntarily medicated to improve his mental state to a level that might then allow him to be tried for the crimes. And if found guilty, he could be sentenced to death. So we would be medicating him to get him well enough to possibly kill him.

But wait a minute. If we can involuntarily medicate Weston to possibly kill him, why couldn't we have involuntarily medicated him before the police officers were killed, making all of this unnecessary and conceivably saving two—no, three—lives?

The signs that he needed medication were painfully obvious. In April 1996, he threatened to kill the president and, at the request of the Secret Service, was evaluated at a mental health center in Illinois. In October 1996, Weston threatened to kill a hospital lab technician and was involuntarily hospitalized for two months, during which time he responded well to treatment. When he was released, no follow-up was ordered to make sure he took the medication he needed to remain well.

Like almost half of people with this disease, he has impaired insight into his illness. In his case, he lacks complete awareness of his illness and his need for medication. When untreated, schizophrenia causes damage to the brain, often including the part of the brain we use to assess our own condition. Undeniably, this part of Weston's brain was damaged.

Weston would never take medication voluntarily because he did not believe he was sick. He really believed—and presumably still believes—that there is a "ruby red satellite" in the U.S. Capitol that can be used to reverse time. Weston also was convinced that President Clinton planned to drop an atomic bomb on his Montana cabin. Just recently, Weston told a prison staff member that he was the "commander of all the armies in the world."

Russell Weston was known to be a walking time bomb for at least two years before he came to Washington to "save the world from cannibals." Local and federal law enforcement officials in both Illinois and Montana were very aware of his mental state and threats. The hospital staff in Montana even said that he reminded them of Theodore Kaczynski, the Unabomber, who also unknowingly suffers from paranoid schizophrenia. So why wasn't he medicated to keep him from being dangerous? Because he had not done enough to prove his dangerousness. Because it would have violated his civil rights. Because the thinking of many public mental health officials appears to be as confused as the thinking of Russell Weston.

Now that Mr. Weston has done something, then maybe we can involuntarily medicate him to get him ready to be tried for something he appears to have done because we did not treat him before. There are literally thousands of Russell Westons roaming America's streets today—individuals with untreated schizophrenia and manic-depressive illness. People with severe mental illness who are being treated are not more dangerous than the general population, but those who are not being treated are. Department of Justice data suggest that such people commit about 1,000 homicides each year, and the number is apparently increasing.

So, tell us again, why can't we treat them? Because state laws governing involuntary treatment often require demonstrated dangerousness before we can intervene. Because local judges and mental health officials often interpret even these restrictive laws very narrowly. Because we are reluctant to infringe on individual civil liberties, even when the person's thinking is completely clouded by illness. Because it is easier to do nothing than something.

Yes, Mr. Weston should be involuntarily medicated so that he can stand trial. And no, he should not be found guilty or executed because of any actions caused by his severe mental illness. And yes, while we are at it, could we also put America's failed mental illness treatment system on trial? But first, let's get it evaluated by a court-appointed psychiatrist to ascertain whether it is mentally competent to stand trial.

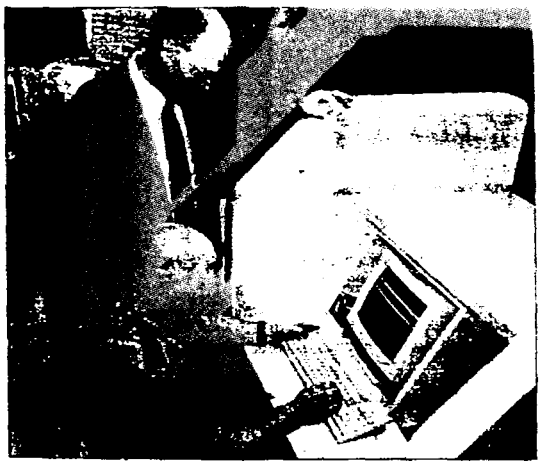
E. Fuller Torrey is president and Mary T. Zdanowicz is executive director of the Treatment Advocacy Center in Arlington, a nonprofit organization working to eliminate barriers to treatment for the severely mentally ill.

EX 12
3/26/01
SB 466

1/28/01

GF Tribune

Prisons trying to duck out from under me



Tribune photo by Wayne Arnst

Cascade County Sheriff John Strandell works in the regional jail with Detention Officer Cpl. Ben Lefever, who is working to get more treatment for mentally ill inmates.

"Our frustration is that once we've identified those people, it's hard to find a program to put them in." — *Cascade County Sheriff John Strand*

By ERIC NEWHOUSE
Tribune Projects Editor

Cascade County is trying to move the mentally ill out of jail and into treatment.

It's part of a national trend as officials realize the nation's courts, jails and prisons are being clogged with people whose crimes stem from mental illness.

Perhaps a quarter of Montana's prison inmates are mentally ill. In fact, the prison holds about three times as many mental patients as the mental hospital in Warm Springs.

Dr. Robert Jones, medical director for the state prison system, told a mental health conference recently that prisons have been asked to handle problems that America doesn't want to deal with.

"If your next-door neighbor is acting a little crazy, the likelihood that individual will end up in a mental institution is not great," Jones said. "Jails have taken over that role because there is no alternative."

A number of psychiatrists say prison is the wrong place to treat the mentally ill, but prison officials answer that there is no other choice: Deinstitutionalization of the nation's mental hospitals left no other place to put such people.

State health officials have begun to put together plans to change that situation.

And now in Cascade County, jailers and deputies have been trained to recognize people with mental problems and get them a psychological evaluation.

"Our frustration is that once we've identified those people, it's hard to find a program to put them in," said Sheriff John Strandell.

"Benefis (Healthcare) does the best it can, but they're limited in what they can do," he said.

That's one reason Strandell fought to include a small psychiatric ward in the new regional jail on Gore Hill, a medical unit run by Montana State University's College of Nursing.

But jails and discipline don't work for some ers who are mentally cording to psychiatrist

"Prisons and jails ar with an assumption person has a logical f ing mind, that a pers understand the rule Dr. E. Fuller Torrey, the Treatment Advoca ter in Arlington, Va.

"But if you have shouting at you or think you'll go thro roof if you raise you you can't follow thes he added in a telepho view.

"So delusional pe into trouble all the t said.

See MENTALL

Mentally ill: Prison is the wrong place, doctor says

FROM 1A

Alternatives to prison are badly needed, experts say.

"For most of the mentally ill, prison is the wrong place," said Dr. Randy Dupont of the University of Tennessee in Memphis.

"There's a small percentage who commit serious crimes and they deserve to be there," Dupont said, "but most of these people are there for behavioral problems.

"That's a mental health problem, not a police problem," he said, "and we shouldn't be asking law enforcement to do our work for us."

Around the country, about 50 communities have begun programs to get treatment for inmates with obvious mental problems.

"There's not a sheriff in the state that isn't concerned with this issue," said Strandell.

"There's a statewide need to divert people out of the criminal justice system and into mental health treatment programs," he said.

Three elements needed

National experts say an effective diversion program has three key elements:

- It requires law enforcement officers committed to funneling patients into treatment instead of jail.
- A specialized mental health hospital must be available around the clock to evaluate defendants dropped off by officers.
- A mental health/drug court needs to supervise patients through treatment until criminal charges, if any, can be dismissed.

Last April, Cascade County commissioners rejected a $30,000 grant from the state to set up a youth drug court, and there's no adult drug court.

However, Congress passed legislation in October authorizing the funding to establish as many as 100 mental health courts around the country. President Clinton signed the bill into law in November.

As to a mental health unit, Great Falls has a 22-bed psych/detox unit at Benefis Healthcare.

Local officers can hospitalize the most obviously ill of their suspects, such as the man who barricaded himself in a house on 2nd Avenue North several months ago.

"We could have arrested him on several charges, but he obviously needed an evaluation by a doctor," said Police Chief Bob Jones. "We never charged him with anything — we just took him to the hospital."

But the hospital may need more help.

"The infrastructure is there in terms of room and staff, but we don't have enough psychiatrists," said Dirk Gibson, administrator of the Addiction Treatment Center at Benefis.

There's enough room on the ward — 15 of the 22 beds usually are full, Gibson said — but it can be difficult to get adequate medical care.

While the hospital provides the space, it doesn't employ the psychiatrists. They're under contract to Golden Triangle and the Great Falls Clinic.

While the doctors are on call 24 hours a day, they carry a full load at their own agencies.

"These psychiatrists are spread very thin already," said Marlene O'Connell, nursing manager of Benefis' Behavior Health Services.

Gibson worried that the psychiatrists would not be able to handle an increased workload.

In Memphis, a jail diversion program increased mental health evaluations and treatment by 40 to 50 percent.

But O'Connell suggested that not all mental health suspects would need to be hospitalized.

"Perhaps they will require outpatient programs or community living, which are currently available through Golden Triangle," she said. "We may need to develop new programs or expand what's already in place."

State has its own plan

In Helena, the Montana Department of Public Health and Human Services also has begun to plan for a mental health diversion program.

An interim subcommittee on mental health has recommended a training course for law enforcement officers, said Dan Anderson, who heads the department's mental and addictive disorders division.

He said the Department of Corrections, which has expertise in that area, could provide the training.

"Another piece we're looking at is called a behavioral health facility," said Anderson.

"A lot of people with mental illness also are chemically dependent, but we don't have a real good way of sorting that out yet," he said.

That could be linked with regional mental health centers around the state, he added.

At Benefis, that suggestion made Gibson bristle.

"Instead of the state starting its own new program, they should be funding the programs that are already in place and building them up," he said.

But state Sen. Bob Keenan, R-Bigfork, disagreed.

"We need regional crisis centers that would provide softer cells for these people," said Keenan, who chairs the Senate Finance Committee.

"For violent crime, you still have to use handcuffs," he added. "But when you're talking about people who need protective custody, it shouldn't be in a jail — and that's going to take some investment."

Anderson said the state hoped to offset increased medical costs with decreasing law enforcement costs.

"My hope would be that we could rearrange our resources to provide these services," he said.

Legislative initiatives

Sen. Mignon Waterman, D-Helena, has introduced legislation to make it easier for judges to commit mentally ill defendants to receive treatment.

Most judges interpret current state law to provide that no person can be sent to a mental institution unless he is an immediate danger to the public or to himself.

Waterman's draft legislation would permit commitment of a person with a previous history of commitment to a mental institution the judge finds the person is not competent to make his own medical decisions.

"This way, a family member who knows something bad is going to happen could get immediate help for someone who has quit taking his meds, for example," Waterman said.

Violation of rights?

Waterman said, however, that some civil libertarians oppose such involuntary treatment, saying it violates a person's rights.

"Our argument is that people with mental illnesses lack insight into their own illness," said Gail Mihelish, a Helena dentist who is the president-elect of the Montana Alliance for the Mentally Ill and who supports the legislation.

"We can't give them treatment but they can end up in our jails sleeping in the park and eating out of garbage cans," Mihelish added. "That just makes no sense to me."

Mihelish said sheriffs and police chiefs across the state are frustrated by the system.

"People are in jail for a short time on misdemeanors, but we have to release them with their mental illness untreated," he said. "So they go right back out and commit another crime.

Montana needs a working mental health diversion program, said Mihelish.

"Sheriff Strandell seems to be pretty progressive — they know what the problems are and they're trying to find ways to deal with it," he said.

"We really endorse this type approach and hope the Legislature will provide funding for approaches like this," said Mihelish.

The debate:

Treat mental illness, punish bad behavior

By ERIC NEWHOUSE
Tribune Projects Editor

Mad vs. bad is a debate that rages among psychiatrists.

Even today, it's difficult to define who is mentally ill vs. who has a personality disorder that makes a person resist authority.

Experts say madness requires treatment, while badness requires punishment.

In Montana, the issue was raised early last year by inmate Mark Walker of Great Falls, who told the Supreme Court he should be treated for his mental illness, not punished for behavior he could not control.

Walker said he spent much of his time in maximum security, locked alone in a chilly cell, often without clothing, a mattress or a pillow.

Prison psychiatrists testified that such treatment, known as "behavior modification programs," was justified because Walker is not mentally ill. They contend he suffers from an anti-social personality disorder.

In the Walker hearing, Dr. Terry Krupers, who has written a book entitled "Prison Madness," testified that it's common for prison psychiatrists to burn out early, discipline the badness and fail to treat the madness.

That's an occupational danger, agreed Dr. Marvin Swartz, professor of psychiatry at Duke University in Durham, N.C.

"Some people treat these people as willfully bad and misbehaving, so they feel it's appropriate to discipline them without an eye to their medical needs," he said.

"But if you hold the view that there's a majority of these people who need medical treatment, we should certainly err on the side of diagnosing and treating people that we think may be mentally ill."

Disruptive prisoner

Walker was serving a five-year sentence on a felony forgery charge and a misdemeanor arson charge when he dictated a note about his treatment to the state Supreme Court.

The doctors at the Colorado Department of Corrections had diagnosed Walker with schizophrenia, but prison doctors at Deer Lodge in a prison setting, which provides shelter, food, medications and treatment in a structured setting.

"I don't buy that," said Dr. Swartz.

"It's more humane and more therapeutic to treat people in hospitals rather than prisons," said Swartz. "But the preferable solution is to treat those people in the community."

Montana has about 9,000 people in its community outpatient programs.

The problem, said Swartz, is the country failed to put adequate resources into community outpatient programs after it nearly emptied its mental hospitals a quarter century ago.

"Imprisoning them represents a failure to adequately treat people in the community," said Swartz.

"The vast majority of the arrests for the mentally ill are for nuisance crimes and often repetitive nuisance crimes," he said. "So why is a person in prison for behavior driven by his sickness?

"Prison has become the treatment program of last resort," said Swartz.

Bad belong in prison

But Paul Appelbaum, head of the department of psychiatry at the University of Massachusetts Medical School, argues that some people with mental disorders deserve prison.

"These are people who have genuine mental disorders that need treatment, but also have personality disorders that make them bad actors," he said.

"For that portion of the population, prison will turn out to be the right answer."

Such people, Appelbaum said, would likely exhibit both serious mental illness and personality disorders.

Mental illness can be thought of as the brain's hard wiring, and often can be corrected through psychotropic medications, said Appelbaum.

Personality disorders are more like soft programming, and are learned behaviors that become a part of the personality.

ommunities around nation working on problem

ERIC NEWHOUSE
oune Projects Editor

Aore than 50 communities oss the country are working to mentally ill inmates out of their is and into treatment.

"I think it's very reasonable for aller communities to try someng like this," said Richard Sherin, who heads the mental health ersion program in Eugene, Ore., ity about twice the size of Great lls.

"The key is having the treatment sources available in the commuty and the criminal justice system a willing participant," said Sherin.

The reason for the programs is at jails and prisons are being ogged with nondangerous ofnders who are mentally ill, alcolic or frequently both.

"All too often these days, these ople are being brought to jails cause it's not clear that their oblem is psychiatric or because ere is no other community opn," said Dr. Paul Appelbaum, airman of the University of ssachusetts department of psyiatry.

"They disturb the peace, urinate public, or break and enter beuse they're confused," he said.

"These people ought to be ought to a psychiatric hospital, her than a jail."

ugene's solution

n Eugene, however, jail provides iversion for such people.

We screen everyone who comes ough the door of our jail for ntal illness and for drug/alcohol pendence," said Sherman.

ail personnel have been trained sk about a prior history of menillness, to determine a suspect's rent mental status and to refer ubling cases for an immediate ntal evaluation.

he mental health triage unit is t of the hospital, which is right t door to the jail.

he program is designed to han- people with mental and subnce abuse problems because rerch has shown that the two sitaneously occur about 75 per- t of the time.

he county attorney decides ether prosecution or medical tment is called for. If it's treatnt, the defendant goes before a cialized court that handles drug se and mental health issues.

here, he or she will admit the s of the case, but the judge will ke no finding.

stead, the defendant begins a tment program of up to one r at a local mental health clinic, ctuated by monthly court ap-

Photo courtesy of the Memphis Police Department

Two Memphis police officers specially trained to deal with the mentally ill assist a homeless man in the city.

There also are jail-based case managers who work with defendants on making appointments, taking medications and showing up in court as scheduled.

"They develop a relationship with these people," Sherman said, "and it's a key element in this process."

The Memphis model

There's a similar program in Memphis, but it intervenes earlier.

Nearly 200 of the city's 1,000 uniformed police officers have volunteered for the Crisis Intervention Team and received 40 hours of specialized training.

They're senior patrol officers with increased maturity and judgment. Most are interested in mental health issues, as well.

Much of their best work is done on the street, listening to people with problems and trying to get them the help they need.

"Some people may feel that's a waste of time, but it can prevent a bigger problem," said Lt. Sam Cochran, who heads the CIT unit.

Police in Memphis receive 7,000 calls per year, and many involve an immediate crisis.

every 100,000 calls; now it's down to 1.9 times per 100,000 calls.

Officer injuries also are down.

In the three years before the program began, the department logged 35 injuries for each 100,000 mental health-related calls. Over the past three years, the rate has dropped to seven injuries per 100,000 calls.

When a suspect has calmed down and admitted he needs help, the officer takes him directly to the University of Tennessee-Memphis mental health clinic for an evaluation.

"We could very easily press a loitering charge or a trespassing charge or a disturbing the peace charge, but the fact that we're able to deliver these people to mental health treatment without placing any criminal charges is a tremendous success," Cochran said.

Use of force

Sometimes, however, a suspect won't calm down.

In that case, officers in Memphis have been trained to subdue them with an Impact Delivery System weapon, a 10-pound rifle that looks like a tommy gun, but shoots a rubber baton at 140 mph.

lesser energy rounds," Cochran said.

The suspect went down, and officers jumped him. He was immediately taken to the hospital.

"Now that's the way the Impact Delivery System is supposed to work," said Cochran. "It saved a life."

Getting results

Dr. Randy Dupont, the psychiatrist who runs the UT mental health hospital in Memphis, said the new system means the mentally ill are getting treatment, not jail time.

"The arrest rate for the mentally ill averages about 20 percent nationally," said Dupont in a telephone interview, "but we have a 2 percent arrest rate."

Since the CIT program began, the psychiatric unit has experienced a growth in patient load between 40 and 50 percent.

It currently averages 400 to 500 psychiatric evaluations per month, with 350 of them brought in by CIT officers.

The success of the Memphis program — and the fact that it's being copied around the country — has prompted the National Institute of Health to fund a study of mental health diversion programs.

Investigators will study how cost effective these programs are com-

Defuse tensions

When dealing with mentally ill individuals, officers with the Memphis Crisis Intervention Team are trained to defuse tense situations.

Among other things, they are trained to use the following techniques:

- Learn and use the individual's name.
- Be polite when making statements or requests.
- Use a nonthreatening stance and keep a "leg's length" between you and the individual.
- Keep your hands in sight and your palms up.
- Keep the tone of your voice low and calm.
- Use the pronoun "I" frequently, as in "I understand."
- Work toward small, concrete goals.
- Distract the individual.
- Listen to the individual's statements and requests.
- Get the individual focused on you, not on others.
- Avoid making promises you can't keep.

EX 13
3/6/01
SB 466

western montana
MENTAL HEALTH CENTER

Dear Mr. Chairman and Committee Members,

I am writing to oppose this legislation. Our current commitment law already allows for community commitment, but is seldom used in most areas of the state. Adding more confusing language to the statute requiring community treatment without funding any additional community treatment will only make matters worse. The Mental Health Advisory Council has already recommended more education for county attorneys and district court judges. They have not recommended these changes to the commitment law. This is not a good bill and I urge you to defeat this unnecessary legislation.

Sincerely,

John Lynn
Deputy Director
Western MT Mental Health Center

AN ACT GENERALLY REVISING THE MENTAL HEALTH COMMITMENT STATUTES; ALLOWING THE COURT TO COMMIT A PERSON TO COMMUNITY TREATMENT FOR A PERIOD NOT TO EXCEED 6 MONTHS; PROVIDING FOR OPTIONAL TREATMENT PLANS, PROVIDER CHOICE, AND CONDITIONS FOR A COMMITMENT TO COMMUNITY TREATMENT; PROVIDING FOR WRITTEN REPORTS BY THE TREATING PROVIDER TO THE COURT; PROVIDING THAT A REFERRAL FOR APPROPRIATE MENTAL ILLNESS PROCEEDINGS IS AN APPROPRIATE CONDITION OF PRETRIAL DIVERSION; DEFINING "MENTAL HEALTH PROFESSIONAL"; ALLOWING FOR AN EXTENSION OF COMMUNITY TREATMENT AT THE REQUEST OF THE RESPONDENT; AND AMENDING SECTIONS 46-16-130, 53-21-102, 53-21-104, 53-21-121, 53-21-123, 53-21-124, 53-21-126, 53-21-127, 53-21-128, AND 53-21-181, MCA.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Conditions of treatment in a community facility, program, or course of treatment. If the court orders a disposition under 53-21-127(3)(b), the court may order the following conditions for treatment in a community facility or program, or may order a course of treatment, including but not limited to:

(1) following a treatment plan developed pursuant to [section 2] that may include case management services, medication, short-term inpatient treatment, chemical dependency treatment, assertive community treatment, or a combination, as set forth by the designated community facility or program or the individual responsible for the management and supervision of the respondent's treatment; or

(2) specific residential or housing requirements that may include being under the care or custody of a relative or guardian.

Section 2. Treatment plan -- provider choice. (1) Stabilizing treatment must be provided during the development of a treatment plan.

(2) If the court orders a treatment plan under this section as a condition of a commitment for treatment in a community facility, program, or course of treatment, the chief medical officer of the facility or program at which the respondent has been ordered to receive outpatient treatment and at which the respondent is treated as an outpatient or the chief medical officer's designee shall submit a treatment plan, including any outpatient treatment recommendations that the respondent is required to follow, to the clerk of district court as soon as practical. However, the plan must be submitted no later than 30 days after the respondent has been ordered to receive treatment as an outpatient.

(3) A treatment plan must be developed with the respondent and the friend of respondent or respondent's family, if family involvement is determined by the court in consultation with the mental health professional to be in the best interests of the respondent.

(4) The clerk of district court shall send a copy of the proposed treatment plan to the court, to the respondent, to the friend of respondent, and to the respondent's attorney of record, who may relay the respondent's objections to the treatment plan, if any, and provide alternative treatment recommendations to the court.

(5) The court may accept the treatment plan or require a revised treatment plan that is approved by a mental health professional.

Section 3. Notification of noncompliance of condition for treatment plan -- response. (1) If the respondent has been ordered to follow a treatment plan and the respondent does not substantially comply with the treatment plan developed pursuant to the order for treatment pursuant to a commitment to a community facility or program or course of treatment, the chief medical officer or designee shall promptly notify the court upon becoming aware of substantial noncompliance that is likely to result in at least one of the conditions in 53-21-126(1) and shall provide supporting documentation.

(2) The court may take reasonable steps to ensure compliance with the court's outpatient treatment order, including but not limited to the following:

(a) directing that the friend of respondent remind the respondent of the respondent's treatment obligations and attempt to persuade the noncompliant respondent to comply with the treatment plan;

(b) presenting the respondent to the mental health facility or program for treatment, including administration of medication pursuant to 53-21-127(6); or

(c) directing the treating provider to work with the respondent to bring about compliance with the treatment plan.

Section 4. Department funding responsibility. The department shall develop a separate funding category and procedure for payment for services that are court-ordered for a commitment to a community facility or program or course of treatment. However, nothing in this chapter obligates the department to pay for services ordered under 53-21-127 unless the respondent is eligible for mental health services under the public mental health system funded by the department, the service is one that the department has included in its mental health program, and the department determines that the mental health service is medically necessary for the respondent.

Section 5. Section 46-16-130, MCA, is amended to read:

"**46-16-130. Pretrial diversion.** (1) (a) Prior to the filing of a charge, the prosecutor and a defendant who has counsel or who has voluntarily waived counsel may agree to the deferral of a prosecution for a specified period of time based on one or more of the following conditions:

(i) that the defendant may not commit any offense;

(ii) that the defendant may not engage in specified activities, conduct, and associations bearing a relationship to the conduct upon which the charge against the defendant is based;

(iii) that the defendant shall participate in a supervised rehabilitation program, which may include treatment, counseling, training, or education;

(iv) that the defendant shall make restitution in a specified manner for harm or loss caused by the offense; or

(v) any other reasonable conditions.

(b) The agreement must be in writing, must be signed by the parties, and must state that the defendant waives the right to speedy trial for the period of deferral. The agreement may include stipulations concerning the admissibility of evidence, specified testimony, or dispositions if the deferral of the prosecution is terminated and there is a trial on the charge.

(c) The prosecution must be deferred for the period specified in the agreement unless there has been a violation of its terms.

(d) The agreement must be terminated and the prosecution automatically dismissed with prejudice upon expiration and compliance with the terms of the agreement.

(2) A condition of pretrial diversion may be for the court to refer a defendant for evaluation to determine the appropriateness of proceedings pursuant to Title 53, chapter 21.

~~(2)~~(3) After a charge has been filed, a deferral of prosecution may be entered into only with the approval of the court.

~~(3)~~(4) A prosecution for a violation of 61-8-401, 61-8-406, or 61-8-410 may not be deferred."

Section 6. Section 53-21-102, MCA, is amended to read:

"**53-21-102. Definitions.** As used in this part, the following definitions apply:

(1) "Board" or "mental disabilities board of visitors" means the mental disabilities board of visitors created by 2-15-211.

(2) "Commitment" means an order by a court requiring an individual to receive treatment for a mental disorder.

(3) "Court" means any district court of the state of Montana.

(4) "Department" means the department of public health and human services provided for in 2-15-2201.

(5) "Emergency situation" means a situation in which any person is in imminent danger of death or bodily harm from the activity of a person who appears to be suffering from a mental disorder and appears to require commitment.

(6) "Friend of respondent" means any person willing and able to assist a person suffering from a mental disorder and requiring commitment or person alleged to be suffering from a mental disorder and requiring commitment in dealing with legal proceedings, including consultation with legal counsel and others. The friend of respondent may be the next of kin, the person's conservator or legal guardian, if any, representatives of a charitable or religious organization, or any other person appointed by the court to perform the functions of a friend of respondent set out in this part. Only one person may at any one time be the friend of respondent within the meaning of this part. In appointing a friend of respondent, the court shall consider the preference of the respondent. The court may at any time, for good cause, change its designation of the friend of respondent.

(7) "Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The term does not include:

(a) addiction to drugs or alcohol;

(b) drug or alcohol intoxication;

(c) mental retardation; or

(d) epilepsy.

(8) "Mental health facility" or "facility" means a public hospital or a licensed private hospital that is equipped and staffed to provide treatment for persons with mental disorders or a community mental health center or any mental health clinic or treatment center approved by the department. A correctional institution or facility or jail is not a mental health facility within the meaning of this part.

(9) "Mental health professional" means:

(a) a certified professional person;

(b) a physician licensed under Title 37, chapter 3;

(c) a professional counselor licensed under Title 37, chapter 23;

(d) a psychologist licensed under Title 37, chapter 17;

(e) a social worker licensed under Title 37, chapter 22; or

(f) an advanced practice registered nurse, as provided for in 37-8-202, with a clinical specialty in psychiatric mental health nursing.

~~(9)~~(10) "Next of kin" includes but is not limited to the spouse, parents, adult children, and adult brothers and sisters of a person.

~~(10)~~(11) "Patient" means a person committed by the court for treatment for any period of time or who is voluntarily admitted for treatment for any period of time.

~~(11)~~(12) "Peace officer" means any sheriff, deputy sheriff, marshal, police officer, or other peace officer.

~~(12)~~(13) "Professional person" means:

(a) a medical doctor; or

(b) a person who has been certified, as provided for in 53-21-106, by the department.

~~(13)~~(14) "Reasonable medical certainty" means reasonable certainty as judged by the standards of a professional person.

~~(14)~~(15) "Respondent" means a person alleged in a petition filed pursuant to this part to be suffering from a mental disorder and requiring commitment.

~~(15)~~(16) "State hospital" means the Montana state hospital."

Section 7. Section 53-21-104, MCA, is amended to read:

"**53-21-104. Powers and duties of mental disabilities board of visitors.** (1) The board is an independent board of inquiry and review to assure that the treatment of all persons either voluntarily or involuntarily admitted to a mental facility is humane and decent and meets the requirements set forth in this part.

(2) The board shall review all plans for experimental research involving persons admitted to a mental health facility to assure that the research project is humane and not unduly hazardous and that it complies with the principles of the statement on the use of human subjects for research of the American association on mental deficiency and with the principles for research involving human subjects required by the United States department of health, education, and welfare. An experimental research project involving persons admitted to a mental health facility affected by this part may not be commenced unless it is approved by the mental disabilities board of visitors.

(3) The board shall at least annually inspect every mental health facility ~~which~~ that is providing treatment and evaluation to any person pursuant to this part. The board shall inspect the physical plant, including residential, recreational, dining, and sanitary facilities. ~~It~~ The board shall visit all wards and treatment areas. The board shall inquire concerning all treatment programs being implemented by the facility.

(4) The board shall annually insure that a treatment plan exists and is being implemented for each patient admitted or committed to a mental health facility under this part. The board shall inquire concerning all use of restraints, isolation, or other extraordinary measures.

(5) The board may assist any patient at a mental health facility in resolving any grievance the patient may have concerning the patient's commitment or course of treatment in the facility.

(6) The board shall employ and be responsible for full-time legal counsel at the state hospital, whose responsibility is to act on behalf of all patients at the institution. The board shall insure that there is sufficient legal staff and facilities to insure availability to all patients and shall require that the appointed

counsel periodically interview every patient and examine the patient's files and records. The board may employ additional legal counsel for representation of patients in a similar manner at any other mental health facility having inpatient capability.

(7) If the board believes that any facility is failing to comply with the provisions of this part in regard to its physical facilities or its treatment of any patient, it shall report its findings at once to the professional person in charge of the facility and the director of the department, and if appropriate, after waiting a reasonable time for a response from the professional person, the board may notify the next of kin or guardian of any patient involved, the friend of respondent appointed by the court for any patient involved, and the district court which has jurisdiction over the facility.

(8) The board shall report annually to the governor concerning:

(a) the status of the mental health facilities and treatment programs which it has inspected; and

(b) medications involuntarily administered to patients in mental health facilities and the effectiveness of the review procedure required by 53-21-127~~(2)~~(6) in protecting patients from unnecessary or excessive medication."

Section 8. Section 53-21-121, MCA, is amended to read:

"**53-21-121. Petition for commitment -- contents of -- notice of.** (1) The county attorney, upon the written request of any person having direct knowledge of the facts, may file a petition with the court alleging that there is a person within the county who is suffering from a mental disorder and who requires commitment pursuant to this chapter.

(2) The petition must contain:

(a) the name and address of the person requesting the petition and the person's interest in the case;

(b) the name of the respondent and, if known, the address, age, sex, marital status, and occupation of the respondent;

(c) the purported facts supporting the allegation of mental disorder, including a report by a mental health professional if any, a statement of the disposition sought pursuant to 53-21-127~~(2)~~, and the need for commitment;

(d) the name and address of every person known or believed to be legally responsible for the care,

support, and maintenance of the respondent for whom evaluation is sought;

(e) the name and address of the respondent's next of kin to the extent known to the county attorney and the person requesting the petition;

(f) the name and address of any person whom the county attorney believes might be willing and able to be appointed as friend of respondent;

(g) the name, address, and telephone number of the attorney, if any, who has most recently represented the respondent for whom evaluation is sought; if there is no attorney, there must be a statement as to whether to the best knowledge of the person requesting the petition the respondent for whom evaluation is sought is indigent and unable to afford the services of an attorney; and

(h) a statement of the rights of the respondent, which must be in conspicuous print and identified by a suitable heading.

(3) Notice of the petition must be hand-delivered to the respondent and to the respondent's counsel on or before the initial appearance of the respondent before the judge or justice of the peace. The respondent's counsel shall meet with the respondent, explain the substance of the petition, and explain the probable course of the proceedings. Notice of the petition and the order setting the date and time of the hearing and the names of the respondent's counsel, professional person, and friend of respondent must be hand-delivered or mailed to the person or persons legally responsible for care, support, and maintenance of the respondent, the next of kin identified in the petition, and any other person identified by the county attorney as a possible friend of respondent other than the one named as the friend of respondent. The notice may provide, other than as to the respondent and the respondent's counsel, that no further notice will be given unless written request is filed with the clerk of court."

Section 9. Section 53-21-123, MCA, is amended to read:

"**53-21-123. Examination of respondent following initial hearing -- recommendation of professional person.** (1) Following the initial hearing, whether before a judge or justice of the peace, the respondent must be examined by the professional person without unreasonable delay. The examination may not exceed a period of 4 hours. The professional person shall immediately notify the county attorney of the findings in person or by phone and shall make a written report of the examination to the court, with copies to the respondent's attorney and the county attorney. If the professional person recommends

commitment, the professional person's written report must contain a statement of the professional person's recommendations to the court for disposition under 53-21-127~~(2)~~.

(2) The following action must be taken based on the professional person's findings:

(a) If the professional person recommends dismissal, the professional person shall additionally notify counsel and the respondent must be released and the petition dismissed. However, the county attorney may, upon good cause shown, request the court to order an additional, but no more than one, examination by a different professional person for a period of no more than 4 hours.

(b) If the court finds that commitment proceedings should continue, the hearing must be held as scheduled.

(3) The court may not order further evaluation pending the hearing unless sound medical reasons require additional time for a complete evaluation. The reasons must be set forth in the order, along with the amount of additional time needed."

Section 10. Section 53-21-124, MCA, is amended to read:

"**53-21-124. Detention of respondent pending hearing or trial -- jail prohibited.** (1) The court may not order detention of a respondent pending the hearing unless requested by the county attorney and upon the existence of probable cause for detention. Counsel must be orally notified immediately. Counsel for the respondent may then request a detention hearing, which must be held ~~forthwith~~ immediately.

(2) In the event of detention, the respondent must be detained in the least restrictive setting necessary to ~~assure his~~ ensure the respondent's presence and ~~assure his safety and~~ ensure the safety of the respondent and of others as provided in 53-21-120.

(3) If the respondent is detained, ~~he~~ the respondent has the right to be examined additionally by a professional person of ~~his~~ the respondent's choice, which may not depend on the respondent's ability to pay, and the respondent must be informed of this right. Unless objection is made by counsel for the respondent, ~~he~~ the respondent must continue to be evaluated and treated by the professional person pending the hearing.

(4) A respondent may not be detained in a jail or other correctional facility pending a hearing or trial to determine whether the respondent should be committed to a mental health facility."

Section 11. Section 53-21-126, MCA, is amended to read:

"**53-21-126. Trial or hearing on petition.** (1) The respondent must be present unless the respondent's presence has been waived as provided in 53-21-119(2), and the respondent must be represented by counsel at all stages of the trial. The trial must be limited to the determination of whether or not the respondent is suffering from a mental disorder and requires commitment. At the trial, the court shall consider all the facts relevant to the issues of whether the respondent is suffering from a mental disorder. If the court determines that the respondent is suffering from a mental disorder, the court shall then determine whether the respondent requires commitment. In determining whether the respondent requires commitment and the appropriate disposition under 53-21-127, the court shall consider the following:

(a) whether the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) whether the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) whether, because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; and

(d) whether the respondent's mental disorder, as demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(2) The standard of proof in a hearing held pursuant to this section is proof beyond a reasonable doubt with respect to any physical facts or evidence and clear and convincing evidence as to all other matters. However, the respondent's mental disorder must be proved to a reasonable medical certainty. Imminent threat of self-inflicted injury or injury to others must be proved by overt acts or omissions, sufficiently recent in time as to be material and relevant as to the respondent's present condition.

(3) The professional person appointed by the court must be present for the trial and subject to cross-examination. The trial is governed by the Montana Rules of Civil Procedure. However, if the issues are tried by a jury, at least two-thirds of the jurors shall concur on a finding that the respondent is

suffering from a mental disorder and requires commitment. The written report of the professional person that indicates the professional person's diagnosis may be attached to the petition, but any matter otherwise inadmissible, such as hearsay matter, is not admissible merely because it is contained in the report. The court may order the trial closed to the public for the protection of the respondent.

(4) The professional person may testify as to the ultimate issue of whether the respondent is suffering from a mental disorder and requires commitment. This testimony is insufficient unless accompanied by evidence from the professional person or others that:

(a) the respondent, because of a mental disorder, is substantially unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety;

(b) the respondent has recently, because of a mental disorder and through an act or an omission, caused self-injury or injury to others;

(c) because of a mental disorder, there is an imminent threat of injury to the respondent or to others because of the respondent's acts or omissions; or

(d) (i) the respondent's mental disorder:

(A) has resulted in recent acts, omissions, or behaviors that create difficulty in protecting the respondent's life or health;

(B) is treatable, with a reasonable prospect of success;

(C) has resulted in the respondent's refusing or being unable to consent to voluntary admission for treatment; and

(ii) will, if untreated, predictably result in deterioration of the respondent's mental condition to the point at which the respondent will become a danger to self or to others or will be unable to provide for the respondent's own basic needs of food, clothing, shelter, health, or safety. Predictability may be established by the respondent's relevant medical history.

(5) The court, upon the showing of good cause and when it is in the best interests of the respondent, may order a change of venue."

Section 12. Section 53-21-127, MCA, is amended to read:

"**53-21-127. Posttrial disposition.** (1) If, upon trial, it is determined that the respondent is not suffering from a mental disorder or does not require commitment within the meaning of this part, the

respondent must be discharged and the petition dismissed.

(2) ~~(a)~~ If it is determined that the respondent is suffering from a mental disorder and requires commitment within the meaning of this part, the court shall hold a posttrial disposition hearing. The disposition hearing must be held within 5 days (including Saturdays, Sundays, and holidays unless the fifth day falls on a Saturday, Sunday, or holiday), during which time the court may order further evaluation and treatment of the respondent.

(3) At the conclusion of the disposition hearing and pursuant to the provisions in subsection (7), the court shall:

~~(i)~~(a) commit the respondent to the state hospital for a period of not more than 3 months; or

~~(ii)~~(b) commit the respondent to a community facility~~,~~ or program~~,~~ or to any appropriate course of treatment, which may include housing or residential requirements, for a period of not more than ~~3~~ 6 months~~;~~

~~(iii) order the respondent to be placed in the care and custody of a relative or guardian or some other appropriate place other than an institution;~~

~~(iv) order outpatient therapy; or~~

~~(v) make some other appropriate order for treatment~~.

~~(b)~~(4) ~~A~~ Except as provided in subsection (3)(b), a treatment ordered pursuant to this ~~subsection~~ section may not affect the respondent's custody or course of treatment for a period of more than 3 months.

~~(c)~~(5) In determining which of the alternatives in subsection ~~(2)(a)~~ (3) to order, the court shall choose the least restrictive alternatives necessary to protect the respondent and the public and to permit effective treatment.

(6) The court may authorize the chief medical officer of a facility or a physician designated by the court to administer appropriate medication involuntarily if the court finds that involuntary medication is necessary to protect the respondent or the public or to facilitate effective treatment. Medication may not be involuntarily administered to a patient unless the chief medical officer of the facility or a physician designated by the court approves it prior to the beginning of the involuntary administration and unless, if possible, a medication review committee reviews it prior to the beginning of the involuntary administration or, if prior review is not possible, within 5 working days after the beginning of the

involuntary administration. The medication review committee must include at least one person who is not an employee of the facility or program. The patient and the patient's attorney or advocate, if the patient has one, must receive adequate written notice of the date, time, and place of the review and must be allowed to appear and give testimony and evidence. The involuntary administration of medication must be again reviewed by the committee 14 days and 90 days after the beginning of the involuntary administration if medication is still being involuntarily administered. The mental disabilities board of visitors and the director of the department of public health and human services must be fully informed of the matter within 5 working days after the beginning of the involuntary administration. The director shall report to the governor on an annual basis.

~~(d)~~(7) Satisfaction of any one of the criteria listed in 53-21-126(1) justifies commitment pursuant to this chapter. However, if the court relies solely upon the criterion provided in 53-21-126(1)(d), the court may require commitment only to a community facility or program or an appropriate course of treatment as provided in subsection (3)(b), and may not require commitment at the state hospital.

~~(e)~~(8) In ordering commitment pursuant to this section, the court shall make the following findings of fact:

~~(i)~~(a) a detailed statement of the facts upon which the court found the respondent to be suffering from a mental disorder and requiring commitment;

~~(ii)~~(b) the alternatives for treatment that were considered;

~~(iii)~~(c) the alternatives available for treatment of the respondent;

~~(iv)~~(d) the reason that any treatment alternatives were determined to be unsuitable for the respondent;

~~(v)~~(e) the name of the facility, program, or individual to be responsible for the management and supervision of the respondent's treatment;

~~(vi)~~(f) if the order includes a requirement for inpatient treatment, the reason inpatient treatment was chosen from among other alternatives; ~~and~~ and

~~(viii)~~(g) if the order includes involuntary medication, the reason involuntary medication was chosen from among other alternatives."

Section 13. Section 53-21-128, MCA, is amended to read:

"53-21-128. **Petition for extension of commitment period.** (1) (a) Not less than 2 calendar weeks prior to the end of the 3-month period of commitment to the state hospital or the period of commitment to a community facility or program or a course of treatment provided for in 53-21-127~~(2)~~, the professional person in charge of the patient at the place of commitment may petition the district court in the county where the patient is committed for extension of the commitment period unless otherwise ordered by the original committing court. The petition must be accompanied by a written report and evaluation of the patient's mental and physical condition. The report must describe any tests and evaluation devices that have been employed in evaluating the patient, the course of treatment that was undertaken for the patient, and the future course of treatment anticipated by the professional person.

(b) Upon the filing of the petition, the court shall give written notice of the filing of the petition to the patient, the patient's next of kin, if reasonably available, the friend of respondent appointed by the court, and the patient's counsel. If any person notified requests a hearing prior to the termination of the previous commitment authority, the court shall immediately set a time and place for a hearing on a date not more than 10 days from the receipt of the request and notify the same people, including the professional person in charge of the patient. If a hearing is not requested, the court shall enter an order of commitment for a period not to exceed 6 months.

(c) Procedure on the petition for extension when a hearing has been requested must be the same in all respects as the procedure on the petition for the original 3-month commitment except the patient is not entitled to trial by jury. The hearing must be held in the district court having jurisdiction over the facility in which the patient is detained unless otherwise ordered by the court. Court costs and witness fees, if any, must be paid by the county that paid the same costs in the initial commitment proceedings.

(d) If upon the hearing the court finds the patient not to be suffering from a mental disorder and requiring commitment within the meaning of this part, the patient must be discharged and the petition dismissed. If the court finds that the patient continues to suffer from a mental disorder and to require commitment, the court shall order commitment~~, custody in relatives, outpatient therapy, or other order~~ as set forth in 53-21-127~~(2)~~(3). However, an order may not affect the patient's custody for more than 6 months. In its order, the court shall describe what alternatives for treatment of the patient are available, what alternatives were investigated, and why the investigated alternatives were not found suitable. The court may not order continuation of an alternative that does not include a comprehensive, individualized

plan of treatment for the patient. A court order for the continuation of an alternative must include a specific finding that a comprehensive, individualized plan of treatment exists.

(2) Prior to the end of the period of commitment to a community facility or program or course of treatment, a respondent may request that the treating provider petition the district court for an extension of the commitment order. The petition must be accompanied by a written report and evaluation of the respondent's mental and physical condition, an updated treatment plan, and a written statement by the respondent that an extension is desired. The extension procedure must follow the procedure required in subsections (1)(b) through (1)(d).

~~(2)~~(3) Further extensions under subsection (1) or (2) may be obtained under the same procedure described in subsection (1)~~;~~. ~~however~~ However, the patient's custody may not be affected for more than 1 year without a renewal of the commitment under the procedures set forth in subsection (1), including a statement of the findings required by subsection (1)."

Section 14. Section 53-21-181, MCA, is amended to read:

"**53-21-181. Discharge during or at end of initial commitment period -- patient's right to referral.** (1) At any time within the ~~3-month~~ period of commitment provided for in 53-21-127~~(2)~~, the patient may be discharged on the written order of the professional person in charge of ~~him~~ the patient. ~~In the event~~ If the patient is not discharged within the ~~3-month~~ period of commitment and if the term is not extended as provided for in 53-21-128, ~~he shall~~ the patient must be discharged by the facility at the end of ~~3 months~~ the period of commitment without further order of the court. Notice of the discharge ~~shall~~ must be filed with the court and the county attorney at least 5 days prior to the discharge.

(2) Upon being discharged, each patient has a right to be referred, as appropriate, to other providers of mental health services."

Section 15. Codification instruction. [Sections 1 through 4] are intended to be codified as an integral part of Title 53, chapter 21, part 1, and the provisions of Title 53, chapter 21, part 1, apply to [sections 1 through 4].

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